A MEDICARE PRESCRIPTION DRUG SAFETY NET: CREATING A TARGETED BENEFIT FOR LOW-INCOME SENIORS

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

SEPTEMBER 24, 2003

Serial No. 108–86

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

91–048 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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A MEDICARE PRESCRIPTION DRUG SAFETY NET: CREATING A TARGETED BENEFIT FOR LOW-INCOME SENIORS

WEDNESDAY, SEPTEMBER 24, 2003

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 12:05 p.m., in room 2154, Rayburn House Office Building, Hon. Dan Burton (chairman of the subcommittee) presiding.

Present: Representatives Burton, Watson and Cummings.

Staff present: Mark Walker, chief of staff; Brian Fauls, professional staff member; Mindi Walker, professional staff member and clerk; Nick Mutton, press secretary; Danielle Perraut, intern; Tony Haywood, minority counsel; and Teresa Coufal, minority assistant clerk.

Mr. BURTON. Good afternoon. A quorum being present, the Subcommittee on Human Rights and Wellness will come to order.

I ask unanimous consent that all Members' and witnesses' written and opening statements be included in the record. And without objection, so ordered.

I ask unanimous consent that all articles, exhibits, and extraneous or tabular material referred to be included in the record. Without objection, so ordered.

I ask unanimous consent that the following Members of Congress be permitted to serve as members of the subcommittee for today's hearing, Representative Calvin Dooley, Delegate Donna Christensen. Without objection, so ordered.

Today's hearing is a continuation of the subcommittee's investigation into the high cost of prescription drugs in this country. As we have heard at previous hearings on this subject, American consumers pay a higher price on average for prescription drugs than citizens of any other country in the whole world. And the prices continue to go up and up. I have been told that over the last couple 3 years the price of prescription drugs has been increasing somewhere between 15 and 17 percent a year, and that is way, way, way above the growth of the economy and everything else in the area of medicine.

Thanks to the astronomical growth in prices, we now have a situation in this country where more than one out of five American adults are unable to take their drugs as prescribed because they simply cannot afford to buy them. That is terrible; one out of five.

So we are acutely aware that something needs to be done to provide seniors with some relief from the high cost of prescription drugs.

On June 27, 2003, in an extremely close vote, in fact, it was a one vote margin and they had to keep the machine open for about an hour to get that extra vote, the Medicare Prescription Drug Modernization Act passed, H.R. 1.

At first glance, H.R. 1 might appear to be the answer to the prayers of every Medicare beneficiary who has been faced with paying outrageous prices for prescription drugs. However, when you start to examine the details of the legislation, it becomes very clear that the bill creates an ill-conceived and incredibly expensive new open-end entitlement that places a tremendous financial yoke around the neck of American taxpayers for decades and decades to come. There is no provision for negotiation between the Government and the pharmaceutical companies on the price of pharmaceuticals and so they can charge whatever the market will bear, and they have been doing that in the United States already. So the taxpayers will be bearing that burden that is already being borne by the consumers themselves.

As reported in the Wall Street Journal, researchers with Texas A&M University have estimated that the Government's unfunded obligation for a new Medicare prescription drug benefit could be anywhere from $6 trillion to a high of approximately $12 trillion over the life of the program. And that is on top of Medicare's existing unfunded liability already estimated to be $30 trillion.

At the same time, H.R. 1 potentially threatens the prescription drug coverage of millions of American seniors who already have comprehensive coverage through an employer-sponsored retirement plan. I have been told, and we are checking this right now, that as much as 70 percent of the seniors in this country already have prescription drug coverage of one form or another. And I can tell you, almost without doubt, that the minute we pass a Medicare prescription drug benefit, many of those companies, in fact, probably most of them, are going to dump their employees into the Medicare prescription drug program, and that is going to add an unusually large burden on the taxpayer and is going to cost billions and trillions of dollars. Right now, they already have that coverage, and it seems to me rather than give coverage to people who are already covered, we ought to take care of those who are indigent, cannot afford it and do not have it, or those who cannot get it because of health reasons, and that is about 30 percent of the senior population.

It is my sincere hope that the joint House-Senate conference currently working to resolve the differences between H.R. 1 and the Senate's Medicare prescription drug bill, S. 1, will be able to produce a far better bill than the one that passed the House of Representatives back in June. I firmly believe the consequences of passing a bad bill will seriously outweigh the consequences of passing no bill at all. It is better to not pass anything than to pass one that is really going to be a pain for the American people.

A perfect example of what can happen when Congress passes a bad bill is the catastrophic health care legislation that was passed in 1988. The vote, I remember the vote being only 11 votes against

it, but according to the record that we have, maybe this was a separate vote, the vote was 328 to 72, and I was one of the people that opposed it. We were vilified by the seniors across the this country because they said we did not care about them and we should have voted for that catastrophic health care bill. And I remember telling a lot of the seniors that wrote to me and talked to me, I said wait until you find out what is in that turkey and you are going to wish you had not passed it.

And so what happened, less than a year later when they found out about it, they were chasing Dan Rostenkowsi, the chairman of the House Ways and Means Committee, and beating on his car because it was such a rotten bill. And yet a year earlier those of us who had voted against it were a bunch of bad guys and we were vilified. And poor Dan had his car damaged because they found out it was such a bad bill. In an unusually speedy turnaround, as I said, we repealed it by a vote of 360 to 66.

Now we owe it to American seniors as well as our children and grandchildren to move cautiously on creating a Medicare prescription drug benefit. It needs to be both responsive to the needs of seniors as well as fiscally responsible. To settle for anything less is to invite disaster and the wrath of the American taxpayer and consumer.

Someone argued that not passing a conference report would be political suicide. And I would agree with that if the only alternative were to simply do nothing to help Medicare beneficiaries without prescription drug coverage. However, that is not the only alternative.

This afternoon we are going to hear from several witnesses regarding the viability of enacting a Medicare prescription drug safety net focused exclusively on meeting the prescription drug needs of the most vulnerable Medicare beneficiaries, the approximately, I do not know how many Medicare eligible Americans who have no drug coverage at all, the approximately 10 million Medicare eligible Americans who have no drug coverage at all.

I have asked all of our witnesses to comment on a proposal that I asked the subcommittee staff to draft during the August work period. I will not go into too much detail here, as members of the subcommittee have already seen the proposal. I presume you have, Ms. Watson.

Ms. WATSON. Yes.

Mr. BURTON. I will say that what we have put together is an idea for a program that we believe is fiscally responsible as well as responsive to the needs of low-income Medicare beneficiaries who are unable to obtain other forms of prescription drug coverage. Each recipient in the program would receive a Federal contribution into a MSA, medical savings account, with the Federal payment scaled from $2,500 to $600 depending on the recipient's most current income level, with the Federal Government providing 100 percent coverage for prescription drug costs beyond a catastrophic threshold of $3,000. Which means, if they have the ability and have an income that would demand we put $2,500 into an MSA account, that would cover them for the first $2,500, then the next $500 they have would to pay out of their own pocket, and then above that

$3,000 limit the Government would pay for all the costs for prescription drugs.

In order to contain the cost of the program and prevent it from becoming a runaway entitlement, which is something that we cannot afford according to the studies that I have seen, I mean, $7, $8, $10 trillion over the next 10–15 years is something that we just do not have, in order to contain the cost of the program and prevent it from becoming a runaway entitlement, we provide a hard dollar cap on the program expenses over a 10 year period of $200 billion.

In addition, we also give the Secretary of HHS the power to negotiate discount drug prices on behalf of beneficiaries. One of the things I cannot understand, and I wish everybody in America could hear this, is why in the world, if the Federal Government is going to be buying prescription drugs by the millions and millions and millions of dollars in pills, why can we not negotiate with the pharmaceutical companies on the cost of the prescription drugs that we are buying. But there is a prohibition against that.

There is nothing in the legislation that allows our Government to negotiate the prices that the American people are going to pay through Medicare for these prescription drugs. It makes no sense. And we are not talking about cost controls. We are talking about negotiations that would provide a profit for the pharmaceutical companies and the best price for the American taxpayer as well as the recipients.

Right now Tomoxifin, and I have used this example many, many times, if you do not have coverage of any kind, it can cost up to $360 for a 30-day supply in the United States. If a woman has breast cancer and she does not have any coverage, that is a lot of money, $360 for 30 days. In Canada it costs $50. In Germany it costs $60 for the very same thing. Now why in the world we cannot negotiate prices when we are talking about a Medicare prescription drug benefit is beyond me.

The power to negotiate is perhaps the most crucial component of my proposal. Without this leverage, the Government would not be able to obtain the best price possible from the drug companies. We have seen how positively negotiated pricing works in the Department of Veterans Affairs. They negotiate prices over at the Department of Veterans Affairs, and we cannot get that information. I am going to write a letter to VA to find out what they are paying and how they negotiate those prices. But it is not in the public domain and we cannot get it. I guess we will have to break some heads to get it. We need to find out how they are negotiating over there with the pharmaceutical companies and what they are paying and how it works. It makes sense to carry that successful experiment over to Medicare prescription drug programs.

Have we put together a perfect proposal? No, I am sure we have not. But the proposal on the table is, in my opinion, a good starting point for the discussion about a targeted and cost-effective prescription drug benefit. I expect to hear some constructive suggestions from our witnesses regarding improvements to the proposal, and I look forward to listening to their expert suggestions and discussing their ideas. I want to thank you very much for coming here today.

I appreciate your coming today, especially since we had to postpone the hearing from last week.

With that, I will now recognize the ranking member of the subcommittee, Representative Watson.

Ms. WATSON. Thank you so much, Mr. Chairman. Medicare beneficiaries have waited a long time for help. But, unfortunately, the House legislation falls short of what seniors and disabled Americans have been waiting for. Mr. Chairman, I want to especially commend you for your leadership and your strong resolve on this issue. I am pleased to see members from both sides of the aisle working to provide a prescription drug benefit that targets our seniors in order to help them in a practical manner.

Price discrimination in the U.S. market is particularly harmful to the elderly who may rely on multiple medications to manage or treat one or more chronic conditions or illnesses. The lack of a prescription drug benefit under the Medicare program has meant that most seniors must pay most of the cost of prescription drugs out of their own pockets. A Medicare prescription drug benefit should be, first, affordable, reducing the exorbitant prices of drugs; and meaningful, with guaranteed benefits; within Medicare; and available to all regardless of where they might live.

So it is with great disappointment that I look at the proposals that came to the House for Medicare reform. The House bill fails to meet each one of the basic standards.

The House bill does nothing to reduce the cost of prescription drugs. It creates a coverage gap so wide that almost 50 percent of seniors will fall into it. Under the bill, seniors pay the first $250 of their drug costs, then 20 percent of the drug costs up to $2,000. They will receive no assistance at all between $2,000 and $4,900. That is what we call the "donut hole." They will fall into that hole and have to make the decisions, that too many of them have to make, whether to buy food or to buy drugs, or to buy half the prescription in order to pay between $2,000 and $4,900.

The bill also allows insurers to vary their benefit levels and prices around the country. Insurers will be able to limit access to specific drugs and to pharmacies in particular places in this country. The bill even prohibits the Secretary of Health and Human Services, as the chairman has alluded to, from negotiating a better price for seniors. I do not understand that. And particularly in a State like mine, California, we have been able to negotiate better prices when we volume buy, because we have, Mr. Chairman, what we call the "graying" of California and our senior voters demand that we respond in Medicare to their needs.

The bill passed by the House is designed to privatize Medicare, leaving seniors at the mercy of the HMOs, someone on the other end of that phone who does not have a clue making a decision. You know when the doctor prescribes and they have to call to get clearance to go forward, they get a secretary type who makes a decision, or they get a busy signal, or they have to wait in line for the call to be picked up. That is not the way we want to treat our seniors. This bill uses private drug-only plans to administer the prescription drug program. These are plans that do not exist anywhere today.

So, Mr. Chairman, I would like to say that we have now testifying our most esteemed colleagues, Representative Cal Dooley from my own home State, and then we will have Representative Donna Christian-Christensen, who is the one who heads up our Congressional Black Caucus Brain Trust. I just left her at one of our meetings at the Convention Center. But she has had periodic meetings where people come to Washington, DC, and they tell us how we are to make policy. Their guidance is very important. So she will come and talk about that experience and share her insights on health care in the United States, and particularly as an advocate of affordable prescription drugs. So I look forward to your testimony, Mr. Dooley, and to her testimony as well.

I want to apologize for having to go back and be on duty with our Brain Trust that is over at the Convention Center. Thank you so much for this opportunity. I yield back.

Mr. BURTON. Thank you, Ms. Watson. Is Delegate Christensen here?

Ms. WATSON. She is on her way.

Mr. BURTON. OK. We will go ahead and start with Congressman Dooley. We appreciate very much our esteemed colleague being here. You are recognized for your statement.

STATEMENT OF HON. CALVIN DOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. DOOLEY. Thank you, Mr. Chairman, and thank you, Congresswoman Watson, too, for the opportunity to testify on the important issue of Medicare prescription drug coverage. As the conference committee continues to struggle with a reconciliation of the House and Senate-passed bills, many seniors, advocacy groups, and Members of Congress have recognized, as have both of you, that there is a better way to provide universal, affordable Medicare drug benefit to our Nation's seniors.

I would like to also spend a little bit of time talking about a bill that I introduced that we had over 45 Democrats co-sponsor as well as a Republican co-sponsor. This legislation was H.R. 1568, the Medicare RX Now Act. It provided a universal zero premium Medicare drug benefit that would target assistance to seniors who need the most help—the Nation's sickest and the lowest-income seniors—and provide market-based discounts for all Medicare beneficiaries. As you recognize, the majority of seniors already have some form of prescription drug coverage, and our benefit was designed to maintain existing coverage provided by employers, by the States, and by private insurance options. In addition, we designed our benefit with the goal of spending no more than the $400 billion provided in the Republican budget.

We need I think to also provide for an element of universal coverage for this prescription drug benefit. And we have tried to obtain that with universal coverage for high drug costs. Under H.R. 1568 all seniors would be entitled to a new Medicare Part B drug benefit at no additional premium. Each senior would select a Medicare approved drug card that would provide him or her with immediate access to negotiated prices, projected to save that senior anywhere between 10 and 20 percent off the prices they currently pay. This card would also act as an accounting mechanism to track all

drug spending. Seniors with very high drug costs—in excess of $4,000 a year—would trigger the catastrophic benefit, and then the Government would pay roughly 80 percent of the drug costs after that $4,000 has been triggered and the individual would pay a flat co-pay.

Because the coverage would be automatic and provided at no additional premium, it would avoid the adverse selection problems that plague many other proposals and provide seniors with a new benefit for no additional out-of-pocket cost to seniors.

And I would also like to reference the importance of integrating this drug benefit into Medicare Part B, because if we do not do that, we can set up a serious problem of adverse selection. And as a policy, we should be indifferent to whether the health care that is providing the benefit to a senior is pharmaceutical-based care, doctor-based care, or hospital-based care. We do not want to do what the House bill has done where you create a Part D stand alone prescription drug benefit. That could, in fact, create a situation where you will have rising premiums on that drug benefit but in many instances we might have the development of a drug that could be cost-effective. We might see the development of a drug that is effective at limiting the amount of dialysis treatment, that drug could be expensive, that premium would go up, but we would have no recognition of the savings that could potentially accrue to the Part A and the Part B. So that is one of the reasons why we have integrated our plan into Medicare Part B.

We also acknowledge, as you do, we do not have enough money to provide a universal benefit that provides first dollar coverage to every senior on Medicare today. So we agree with you that we ought to target that assistance to those most in need. Considering the current budget shortfalls and the projected deficits for years to come, we must target our resources to seniors with the greatest need. In addition to the universal benefit for all seniors who incur very high drug costs, our legislation recognizes that some low-income seniors do not have the ability to pay large deductibles and need immediate assistance.

Under H.R. 1658, seniors up to 200 percent of poverty would be eligible for first dollar coverage with a three-tiered individual co-payments; giving a lower co-payment for a generic, a little bit higher co-payment for a preferred drug, and a very high co-payment for a non-preferred. Seniors above the full Medicaid eligibility but below 135 percent of poverty would pay flat co-payments equivalent to about an 80–20 cost share. Those seniors with incomes between 135 and 150 percent of poverty would receive a subsidy equivalent to about a 70–30 co-pay. And States would have the option of covering seniors between 150 percent and 200 percent of the Federal poverty level where the Federal Government would match the State payments at the existing SCHIP rate.

The most important thing, which you recognize, our plan, as yours, would not disrupt current coverage. H.R. 1568 recognizes the first principle of medicine—to do no harm. We cannot afford to enact a Medicare prescription drug benefit that would leave the majority of seniors who already have some form of prescription drug coverage worse off than they are today. According to CBO, under the proposals being considered by the conference committee,

between 37 and 32 percent of employers who provide retiree drug coverage today would drop their existing coverage. That translates into almost 4 million beneficiaries losing their existing employer-sponsored prescription drug coverage. It is unconscionable to think that we would enact a drug benefit that would spend hundreds of billions of dollars to make seniors worse off than they are today.

My legislation would not require seniors to switch out of their current coverage to get the new drug benefit. Instead, it would reinforce all current forms of drug coverage, including employer-based retiree coverage and State-based pharmaceutical assistance programs. Because its benefits are based on all drug spending, including drugs purchased under insurance plans seniors already have, not just out-of-pocket, the proposal is fair to seniors who have existing coverage and to the employers who provide it. This will provide an incentive for employers to maintain their coverage, unlike the House plan or the Senate plan that has passed that gives a tremendous incentive for employers to reduce or eliminate their prescription drug coverage. With the deficit for fiscal year 2004 approaching $500 billion, it is fiscally irresponsible to replace prescription drug coverage financed by private sectors dollars with Federal dollars.

Thank you, Mr. Chairman, for the opportunity to testify today. In summary, we need to enact a Medicare prescription drug bill that provides a benefit that seniors can understand, that targets the most assistance to seniors with high drug costs and with low incomes, and keeps employers and States in the system. The Medicare RX Now Act is easy to understand and within the Medicare Part B system that seniors trust.

I look forward to working with you and members of your committee and the rest of our colleagues toward enacting a Medicare prescription drug benefit that our Nation's seniors deserve.

[The prepared statement of Mr. Dooley follows:]

Testimony by Rep. Cal Dooley
House Committee on Government Reform
Subcommittee on Human Rights and Wellness
September 24, 2003

Thank you, Mr. Chairman, for the opportunity to testify today on the important issue of Medicare Prescription Drug Coverage. As the Conference Committee continues to struggle with a reconciliation of the House and Senate-passed bills, many seniors, advocacy groups, and Members of Congress have recognized there is a better way to provide a universal, affordable Medicare drug benefit to our nation's seniors.

Earlier this year I introduced H.R. 1568, the Medicare RX Now Act, a universal zero-premium Medicare drug benefit that would target assistance to seniors who need the most help – the nation's sickest and lowest-income seniors – and provide market-based discounts for all Medicare beneficiaries. Recognizing that a majority of seniors already have some form of prescription drug coverage, our benefit was designed to maintain existing coverage provided by employers, states and private insurance options. In addition, we designed our benefit with the goal of spending no more than the $400 billion provided in the Republican budget.

Universal Coverage for High Drug Costs

Under H.R. 1568 all seniors would be entitled to a new Medicare Part B drug benefit at no additional premium. Each senior would select a Medicare Approved Drug Card Plan that would provide him or her with immediate access to negotiated prices, projected to save that senior anywhere between 10 and 20 percent off the price they currently pay. The card would also act as an accounting mechanism to track all drug spending. Seniors with very high drug costs – in excess of $4,000 a year – would trigger

a catastrophic benefit. The government would pay roughly 80 percent of drug costs after $4,000 and the individual would pay a flat co-payment.

Because the coverage would be automatic and provided at no additional premium it would avoid the adverse selection problems that plague many other proposals and provide seniors with a new benefit for no additional out of pocket cost to the senior.

Targeted Assistance to Those Most In Need

Considering current budget shortfalls and projected deficits for years to come, we must target our resources to seniors with the greatest need. In addition to the universal benefit for all seniors who incur very high drug costs, our legislation recognizes that some low-income seniors do not have the ability to pay large deductibles and need immediate assistance. Under H.R. 1568 seniors up to 200 percent of poverty would be eligible for first dollar drug coverage with low three-tiered individual co-payments.

Seniors above full Medicaid eligibility but below 135 percent of poverty would pay flat co-payments equivalent to an 80/20 cost share. Seniors with incomes between 135 percent and 150 percent of poverty would receive a subsidy equivalent to a 70/30 cost share. And states would have the option of covering seniors between 150 percent and 200 percent of the federal poverty level. The federal government would match state payments at the SCHIP level.

Won't Disrupt Current Coverage

H.R. 1568 recognizes the first principle of medicine – to do no harm. We cannot afford to enact a Medicare prescription drug benefit that would leave the majority of seniors who already have some form or prescription drug coverage worse off than they are today. According to CBO, under the proposals being considered by the Conference

Committee, between 37 and 32 percent of employers who provide retiree drug coverage would drop their existing coverage. That translates into almost 4 million beneficiaries losing their existing employer-sponsored prescription drug coverage. It's unconscionable to think that we'd enact a drug benefit that would spend hundreds of billions of dollars to make seniors worse off than they are today.

My legislation would not require seniors to switch out of their current coverage to get the new drug benefit — instead it would reinforce all current forms of drug coverage, including employer-based retiree coverage and state-based pharmaceutical assistance programs. Because its benefits are based on all drug spending — including drugs purchased under insurance plans seniors already have, not just out-of-pocket spending — the proposal is fair to seniors who have existing coverage and to the employers who provide it. With a deficit for FY 2004 approaching $500 billion, it is fiscally irresponsible to replace prescription drug coverage financed by private sector dollars with federal dollars.

Conclusion

Thank you, Mr. Chairman, for the opportunity to testify today. In summary, we need to enact a Medicare prescription drug bill that provides a benefit that seniors can understand, targets the most assistance to seniors with high drug costs and with low-incomes, and keeps employers and states in the system. The Medicare RX Now Act is easy to understand and within the Medicare Part B system that seniors trust.

I look forward to working with you, members of the committee and the rest of our colleagues toward the enactment of the Medicare Prescription Drug benefit that our nation's seniors deserve.

Mr. BURTON. It sounds like you have given this an awful lot of thought, like we have. I would like to take a close look at your plan. I have a couple of questions about it. You said it would be within the constraints that were set in the House bill of about $400 billion over a 10 year period. How do those constraints work? I mean, you are putting a cap on it, but is that a workable cap or is that just a hopeful cap?

Mr. DOOLEY. It is a projected expenditure.

Mr. BURTON. But there is no hard cap on it?

Mr. DOOLEY. There is no hard cap. But I am one who believes very strongly that any benefit that we provide has to be realistic in terms of being affordable and being able to fit within the budget. The model that we have developed is one which allows you to easily adjust in order to obtain the savings that you might need in order to fit within the budget cap. We think, again, that we ought to maintain our priorities, which is to help those seniors in greatest need. Those are the low-income seniors that are struggling today and most likely do not have coverage. So that is where we have a fairly generous benefit at the low income, similar to what you have done.

But on the high cost, the most expensive component of any prescription drug plan is the catastrophic plan and where you kick it in. The majority of the co-sponsors of this legislation recognize that if we have to adjust in order to get savings, we might have to adjust that catastrophic up in order to fit within that $400 billion parameter, if that is still the will of Congress.

Mr. BURTON. That is where we might have a little difference of opinion. But I would like to work with you on that, because if somebody goes above whether it is the medical savings account approach that we have or the approach that you have, they may not be able to afford that 20 percent match, the 80–20 on the catastrophic, above whatever the top is in yours.

Mr. DOOLEY. That is a problem that we recognize. What our response to that would be is that this is a zero-premium benefit because we are rolling this into Medicare Part B. What we think also will happen in the private sector as a result of this is that you will have plans that will be developed that will have more affordable premiums than there are today because we will limit the exposure by the private sector plans to some extent and even employer-based plans because they will then know that once their person that they are covering triggers this cap then they have some limits in terms of what their financial obligations will be. So we think that the marketplace will respond to help provide some insurance products that can help seniors manage that gap.

And the other thing to keep in mind is that those seniors that have incomes less than the 200 percent or 150 percent of poverty will have first dollar coverage indefinitely.

Mr. BURTON. I just have a couple more questions. If I understand you correctly, let us say a person works for General Motors right now and they have a plan that is a good plan, you are saying that there would be a point at which General Motors coverage would stop and they would go into the plan that you have suggested. Right now they would not because they already have that coverage. So it would be a cost savings long-term to General Motors.

Mr. DOOLEY. For a private sector plan that does not have a capped benefit, this could provide some element of savings to them. But what we see happening in the marketplace today in the private sector is that the majority of prescription plans that are being offered are now capping their benefit. Even under a lot of the managed care plans you are seeing the benefits being capped. And so what our plan does recognize is that, yes, we will be assuming some of the financial responsibilities after the private sector plan provided up to that $4,000 in coverage, and from that point on we would have it be a Medicare responsibility.

Mr. BURTON. Well, a lot of the seniors who see a limit to their catastrophic coverage have been able to buy supplemental policies that take them above that. And I am not necessarily for means testing, but in effect that is probably what you are looking at. For those who can afford to buy an excess policy above the catastrophic policy that they have with their company, I do not see why they should not do that. Because if you load that on the back of the American taxpayer and put everybody under the plan, I still think you have a problem with that cap down the road. It could go way, way above the $400 million. That is my major concern. But I would like to work with you on that.

I had one more thing I would like to say. I think whoever made the projection that under the plans that have been discussed so far in the conference only 37 or 32 percent of the companies will drop their plan and put them on the back of the Government, I think that is very, very low. I think that once they see there is a Government plan that is almost all inclusive, I think they are going to drop those things like hot cakes, because they are all looking at the bottom line. So I think that figure is low and that is why I think we need to come up with a more realistic approach.

But I would like very much to work with you on this. Maybe we could take a look at your plan and ours and see where they dovetail and see if we can work something out.

Mr. DOOLEY. I look forward to that, Mr. Chairman.

Mr. BURTON. I appreciate very much you, individually, working so hard on this. So many of us sit around and just wait until a committee does something and then we end up with a real turkey, like we did with that bill back in 1988. So, thank you very much.

Mr. DOOLEY. Thank you.

Mr. BURTON. Is Delegate Christensen here? I guess she has not yet arrived.

Let us go on with our panel of experts that we have here. Our next panel is Joseph Antos of the American Enterprise Institute, Thomas Miller of CATO, Jeff Lemeiux of Progressive Policy Institute, and Ed Haislmaier of the Heritage Foundation. Since we are just discussing these things today, I am not going to swear you fellows in because I do not think you are going to mislead us, and if you do, we will be after you. But I would like to hear what your views are on the plan that we have sent to you. I presume all of you have had a chance to review it; is that correct? And I appreciate very much your institutions taking a hard look at that and looking at alternatives to what has been presented. This is a major, major issue, as you know, and what might end up being one of the

biggest programs we have ever passed in the Federal Government. Mr. Haislmaier, you are recognized.

STATEMENTS OF ED HAISLMAIER, HERITAGE FOUNDATION; JEFF LEMEIUX, PROGRESSIVE POLICY INSTITUTE; THOMAS MILLER, CATO INSTITUTE; AND JOSEPH ANTOS, AMERICAN ENTERPRISE INSTITUTE

Mr. HAISLMAIER. Thank you, Mr. Chairman. I have submitted testimony for the record. I will just take a few minutes to make a few brief points and then we can go on. I am very encouraged that you are looking at an alternative to the legislation that passed the House and Senate this summer. I think there are substantial problems, as you do, with that legislation.

The two biggest problems that I see are, as you have pointed out, the inducement to employers who provide retirees with coverage to drop that coverage or, actually, I would say to scale that coverage back. I think those employers that can drop it will drop it. I am not sure anybody has a good handle on what that number is. I think it is much more certain that the employers who do not drop it will scale it back and they will either conform to the new benefit design or they will provide front-end wrap around coverage and then leave the retiree exposed to the rest of it.

The other problem is, as your colleague pointed out, the donut hole or the strange coverage design. That is simply a function of trying to provide something to everybody but then also squaring it with the principles of insurance, which are that a few people get a lot of the benefit because they are the neediest. So I am encouraged to see that you are pursuing a different path.

Conceptually, there are some similarities to what I would recommend and have recommended in my testimony and what you are pursuing. Essentially, I think that we can all do ourselves a favor by recognizing that a lot of prescription drug expenses are predictable for this population and that the best way to handle it is with some sort of cash equivalent, and that is the approach that you and others have taken in your legislation.

I think where the differences come down on Mr. Dooley's approach, your approach, what I would recommend and what others have is how do you handle the portion that is an insurable benefit or is close to an insurable benefit; meaning some sort of catastrophic coverage. I would simply favor a system in which you had as many options as possible for retirees to obtain catastrophic coverage. You simply say that any employer has to have coverage above X, whatever X is, it could be $10,000, $6,000, whatever, if they are going to offer a plan. We do not care what you do below that, but above that you have to have coverage. You could allow Medi-gap plans to provide the same coverage. You could allow people to offer stand alone plans if they wanted to, certainly the Medicare Plus Choice plans or Medicare Advantage plans, to offer that. And then tell the enrollees here is the cash, and that will vary based on your income, as you do in your proposal, and to get the cash you have to sign up with a plan that provides catastrophic coverage, so we do not wind up coming back and having to deal with that problem, whether you have catastrophic expenses or not.

So it would be voluntary but they would be leaving money on the table if they did not take you up on the offer.

I think it is virtually impossible to spend more money—well, it is not impossible—but it is virtually impossible to spend more money than is already being spent in H.R. 1 and S. 1 on taking that kind of an approach. Essentially, I think you are on the right track here. I think there are some differences in the details.

Finally, I just wanted to address one point that you made in your opening statement, because you asked the question why cannot the Federal Government negotiate prices, could somebody please explain. So let me take a stab at doing that, if you do not mind. Somebody said in a debate I was recently in, I favor the Government using its negotiating power to drive down drug prices, and I flippantly responded that I favored the Government using its negotiating power to drive up your tax payments. My point in that is that Government does not really negotiate. Government ultimately has the power to force you to take their terms. That is why negotiating with the Government is always, whether it is negotiating with the IRS over how much you really owe or negotiating drug prices, is always an uneven playing field and different from private sector entities negotiating.

And finally I would say that, paradoxically, I think the complexity of the whole issue of medical care and prescription drugs is a subset—what is the right price, what is the right treatment, what is the benefit of drug A versus drug B if they are similar. Because of the complexity of that, it argues for, in my view, more market solutions because the market has the flexibility to adapt and adjust quickly as opposed to Government solutions where you have to follow rules and procedures and if they do not exist somebody has to come up with one of them whenever a new case comes along.

So with that, I will conclude. I would be happy to take any questions you have.

[The prepared statement of Mr. Haislmaier follows:]

Testimony of

Edmund F. Haislmaier

Visiting Research Fellow
Center for Health Policy Studies
The Heritage Foundation

Before the Subcommittee on Human Rights & Wellness of the Committee on Government Reform of the U. S. House of Representatives

September 24, 2003

Mr. Chairman and Members of the Committee:

My name is Edmund F. Haislmaier. I am a Visiting Research Fellow in the Center for Health Policy Studies at The Heritage Foundation. The views expressed in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Mr. Chairman, thank you for the opportunity to testify today. As today's hearing illustrates, even after passing H.R. 1 and S. 1 this summer, Congress is still wrestling with the challenge of constructing a Medicare drug benefit that helps those beneficiaries currently without coverage, while not unduly displacing the existing coverage that millions of other seniors currently receive.

It is becoming increasingly clear that a significant number of Medicare beneficiaries are unhappy with Congress's first draft of a drug benefit design, as embodied in H.R. 1 and S. 1.

The two major objections voiced by seniors are the odd benefit design that includes a "coverage gap" or "doughnut hole," and the concern that beneficiaries with employer-provided retiree drug coverage will see that coverage diminished or even eliminated as a result of the legislation.

Adverse Impact on Existing Retiree Coverage.

Let me address the second objection first, since it is a matter of some dispute.

About 30 percent of Medicare beneficiaries, or about 12 million individuals, currently receive prescription drug coverage through employer-provided retiree health benefits plans. The Congressional Budget Office (CBO) estimates, "that 32 percent of the Medicare beneficiaries who would have employer drug coverage under current law would not have their employer provide coverage to supplement the Part D benefit under

H.R. 1; under S. 1, that share is estimated to be 37 percent."[1] Thus, CBO estimates that between 3.8 and 4.4 million Medicare beneficiaries would lose employer-provided prescription drug coverage under the pending legislation.

In contrast, the Employee Benefit Research Institute (EBRI) estimates a much lower likely coverage loss among this group; in the range of 2 percent to 9 percent, or between 240,000 and 1 million.[2] However, the EBRI study also notes that, "We believe most employers will choose to 'wrap-around' Medicare for current retirees, as they generally do today."[3]

These substantial differences in estimates of coverage loss are attributable to different interpretations of the rather limited and imprecise existing survey data on employer-provided retiree benefits.

However, my analysis of the pending legislation leads me to agree with EBRI that the principle effect will be that those employers that don't drop retiree drug coverage will scale-back the coverage they offer to the level of front-end, wrap around coverage for the new Part D benefit.

While I can't offer the Committee a better estimate of how many beneficiaries will lose coverage completely, I am fairly confident that the vast majority of beneficiaries with current employer-provided drug coverage will see the scope of their drug coverage at least diminished as a result of employer responses to this legislation.

Under H.R. 1 and S. 1, an employer that currently offers retiree coverage would be faced with four options:

1) Drop coverage entirely and have its retirees enroll in the new Part D benefit.

2) Keep its existing retiree drug coverage plan as is, and ignore the new Medicare drug benefit.

3) Conform its existing plan to the new law by modifying the plan to make it a "Qualified Retiree Prescription Drug Plan."

4) Scale-back its existing plan to provide retirees with front-end "wrap-around" coverage to supplement the new Part D benefit. The employer might also pay its retirees' share of the premium for the new Part D benefit.

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[1] Congressional Budget Office, " Cost Estimate: H.R. 1, Medicare Prescription Drug and Modernization Act of 2003 and S. 1, Prescription Drug and Medicare Improvement Act of 2003," July 22, 2003.

[2] Dallas L. Salisbury and Paul Fronstin, "How Many Medicare Beneficiaries Will Lose Employment-Based Retiree Health Benefits if Medicare Covers Outpatient Prescription Drugs?" Employee Benefit Research Institute, *EBRI Special Analysis*, July 18, 2003.

[3] Ibid., footnote 5.

Options two and three are not particularly attractive to employers. Ignoring the legislation and maintaining the status quo does nothing for an employer seeking to lower its unfunded retiree health care liabilities. While an employer who pursued option three and conformed its existing plan to the new law would receive new subsidies from Medicare, the employer would still be at risk for much of the costs of the benefit and would still need to administer the benefit. In addition, because the legislation rigidly defines actuarial equivalence, the newly conformed plan would need to look much like the benefit structure of the new Part D benefit. Thus, even if the employer did conform its plan, the retirees would likely see some diminution of coverage relative to what they currently enjoy.

For employers, options one and four are by far the most attractive. Thus it is reasonable to assume that those employers willing and able to discontinue coverage altogether will do so. For the remainder, enrolling their retirees in the new Part D benefit and then providing front-end, wrap-around coverage is both the simplest and cheapest choice.

Unfortunately for retirees, the effect of their employers choosing option four will be to aggregate together all of the cost sharing into a bigger "doughnut hole." This is because under both bills employer insurance payments for cost sharing do not count in calculating the retiree's cost sharing requirements. Thus, under H.R.1 a beneficiary with employer wrap-around coverage that paid the deductible and initial cost sharing would spend nothing out-of-pocket on the first $2,000 of drugs, but would then have to spend the next $3,500 out-of-pocket before the Part D catastrophic benefit kicks in. The employer, however, under this arrangement would be able to cap its retiree drug spending at a maximum of $600 per retiree, or at $1,020 per retiree if the employer also elected to reimburse its retirees for the cost of the Part D premium. The effects under S.1 would be similar.[4]

Coverage Gap.

The second major objection to the pending legislation is the substantial coverage gap or "doughnut hole" in the Part D benefit design.

A basic problem that Congress faces in designing any Medicare drug benefit is that the principles of good insurance collide head on with the principles of good politics. Essentially, any real insurance program collects a little in premium from everybody and pays out a lot in benefits to those few with the greatest need. In contrast, to be popular a government program needs to meet the political demands of giving something to everybody. So Congress has to figure out how to help those with the greatest needs while still giving something to everybody -- or more accurately, giving everybody at least as much -- and preferably more -- than they have now.

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[4] For a more detailed discussion, see Edmund F. Haislmaier, "How Congress's Medicare Drug Provision Would Reduce Seniors' Existing Private Coverage," Heritage Foundation *Backgrounder* No. 1668, July 17, 2003.

It was the attempt to square this circle, while still staying even within the generous budget parameter of $400 billion dollars, which produced the coverage gap design of the Part D benefit in H.R. 1 and S. 1.

An Alternative Approach.

Can Congress still come up with a better drug plan? Yes, I think so, and I am glad, Mr. Chairman, that you are pursuing that option by holding this hearing.

The first step in designing a better plan is to start by admitting to ourselves the basic reality that when it comes to the first thousand dollars or so of a retiree's drug spending we need to think of any subsidies as basically a cash-equivalent. We can all do ourselves a big favor and greatly simplify things if we start by admitting that anyone taking a daily dose of one or more medications for one or more chronic conditions (i.e., many of the elderly), has ongoing drug expenses that in no proper sense of the word can be considered "insurable." Indeed, for many retirees their monthly prescription drug expenses are probably more predictable than their monthly electric bills.

Thus, I believe we should start by figuring out how much cash we want to give each retiree. Next, let's make sure some of that cash is used to buy them insurance coverage for the share of their future drug spending that is less predictable and thus somewhat more insurable. That would be insurance against catastrophic drug expenses. A relatively small number of beneficiaries have very high drug expenses that are unaffordable to the individual, but constitute only a portion of the total program cost. Finally, let's give the beneficiaries the rest of the money in a form that is administratively simple, can only be used on drugs and encourages the appropriate use of generics and the seeking of discounts.

My recommendation is to give Medicare beneficiaries the option of a getting a subsidy for their prescription drugs through a combined debit card and discount card. To get the subsidy they would have to enroll in a private plan that provided catastrophic drug expense insurance. It could be any kind of plan -- existing employer-sponsored plans, Medigap, the new comprehensive Medicare Advantage plans or stand-alone drug plans. Every plan would have a natural incentive to hire a Pharmacy Benefit Manager (PBM) to manage the drug benefit and get discounts. Each plan would give its enrollees a PBM discount card with the debit card feature added on. The first thing deducted from the debit card would be the premium for the catastrophic insurance. The beneficiary could then apply the remaining funds toward the deductibles and copays.

The per-beneficiary subsidy amount could be varied based on income and indexed for inflation. The benefit structure would be a high deductible with a catastrophic stop loss and cost sharing in between – i.e., real insurance. For example, a $1,000 deductible with a $6,000 stop-loss and 50/50 cost sharing in between, would ensure that the beneficiary paid no more than $3,500 out-of-pocket – the same as the House bill, which has a lower total out-of-pocket cost than the Senate bill.

All of the plans providing the coverage would also participate in a national reinsurance pool. The pool would pay any claims above the per-beneficiary stop loss level. Those costs of the pool would then be passed back to all plans as a fixed amount per-enrollee, which in turn would be added on to the premiums. Thus, the selection effects that the plans fear would be adjusted for and everyone would pay an even share of the extra cost of the small minority with high drug spending.

The result would be that Congress could give all seniors essentially low cost, subsidized catastrophic drug insurance, access to discounts on all of their drug purchases (including the share paid for out-of-pocket) and some money left over toward out-of-pocket costs (with more for the low-income).

One advantage of this approach is that more assistance could be targeted to low-income beneficiaries by simply increasing the contribution to their debit cards. Another advantage is that there would be minimal disruption of employer-provided drug coverage for those retirees with such coverage, as those plans would easily qualify to participate and enrollees could spend their subsidy on payments to maintain their existing coverage.

Mr. Chairman, this concludes my prepared testimony. I will be glad to try to answer any questions you or the other members of the Committee may have. Thank you.

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Mr. BURTON. You will have some.

Mr. Lemeiux.

Mr. LEMEIUX. Thank you, Mr. Chairman. I really appreciate the invitation to come talk to you today. And I congratulate you on your effort to try and create a Medicare drug benefit that would work and that could pass possibly even with some bipartisan support. I have four specific suggestions. I will just mention them quickly and if you would like I can answer questions with more explanation or respond to questions in writing from your staff later.

My first point is when you are targeting a benefit to low-income people, if you just limit it to low-income people who do not already have coverage, you can create some bad incentives. If someone, for example, is just as poor as the next person but they have worked all their life to get that retiree drug benefit or they have saved money so that they can afford some sort of Medi-gap coverage, you do not want to create a plan that the irresponsible person over here with the same low-income gets but the person who took responsibility to take care of themselves either through an employer or purchasing something cannot get. So I encourage you to make your low-income benefit available to anybody with low-income, not just people who do not already have coverage. That way people who have already been responsible would not have an incentive to drop the coverage they already have in order to pick up the Government benefit that they need. So that was point No. 1.

Point No. 2 echoes a point that Mr. Dooley made, which is that there is really a right and a wrong way to do catastrophic coverage. I think that the right way is to do catastrophic coverage that is based on total drug spending. So that if people wish, they can get extra insurance below the catastrophic cap and still not disqualify themselves from the catastrophic benefit that is being provided through the Medicare program. Again, this is the sort of benefit that would allow employer coverage to still operate, but then once you hit the cap you are still eligible for the Government catastrophic, for the Medicare catastrophic. That way you do not create an incentive for employers to drop their coverage and, again, for people not to go out and try and take care of themselves.

Both of these two suggestions will raise the cost of your bill. To compensate, you would have to scale back the benefits some for low-income or maybe increase the catastrophic cap some. But both of them are probably the right thing to do to keep incentives for people to be responsible and to keep as much of that private coverage out there still in place.

The third suggestion I would make, and again it echoes Mr. Dooley's plan, is that it is probably appropriate from a social insurance point of view, I believe, and appropriate for trying to attract bipartisan support to try and get the catastrophic coverage of at least some level, even if it is a very high level, to everybody in Medicare, all seniors. It seems like it is appropriate for social insurance, we like to have people get things that are pretty similar regardless of how their circumstances ended up in life, and it just seems appropriate that everyone could be faced with catastrophic drug costs and this social insurance/Medicare should cover that. And then offering extra benefits to seniors with low-incomes seems appropriate and fine.

And then my fourth suggestion echoes something that Ed Haislmaier said, which is, I think it is appropriate to allow all sorts of companies to offer the discount cards that you have put in your bill and that would also have this debit cash and it would also possibly have a catastrophic benefit, whether that is employers offering it, HMOs and PPOs that some people have in some areas, pharmacies, drug companies or coalitions of drug companies, Medi-gap plans, just as pluralistic as possible. I think that would create a healthy market.

My final three points are that, I think when you look at Mr. Dooley's bill, he had a standard sort of insurance for low-income people that has benefits and co-payments, and what you have suggested is a debit card approach where you get cash on your discount card and you could use that to some extent, and I think there are a lot of health analysts, Democrats, Republicans who are very interested in your approach as an alternative and think that might be something they could work with.

The capped entitlement idea that you have put forward I think is also probably something that people on both sides of the aisle that I talk to can work with. I know there was a version of Mr. Dooley's bill that was floating around in the Senate earlier this year as an amendment and it had a capped entitlement approach where we would specify the amount of money and then the Secretary of Health and Human Services would decide, based on that capped amount, what the catastrophic level would be for the upcoming year.

And finally, I helped originate some of the ideas of Medicare reform that came out of the Breaux-Thomas Medicare Reform Commission, I was a staffer for that commission. So I have been a supporter of the premium support idea for some time, but only as it relates to comprehensive health plans where you get all of your health insurance from a Government run plan, you get all of your health insurance from a private plan. The idea of trying to transfer these premium support concepts to a stand alone drug benefit, which I think is what has caused the House-passed plan and the Senate-passed plan to be so problematic, I think that we could make a mistake in developing a more targeted benefit if we tried to privatize too much, if we did not just say, look, after a certain point, if the Government is going to provide a catastrophic benefit, let's say, the Government should just be on the hook for it and it can negotiate risk-sharing arrangements with private entities. But we should not try to place too much of the risk burden off on the marketplace for such a limited benefit, which, as Representative Watson mentioned, there is not a very good market for stand alone drug benefits already. So it is already going to be pretty iffy.

With that, I will be happy to answer any questions you have.

[The prepared statement of Mr. Lemeiux follows:]

Prepared Testimony of Jeff Lemieux
House Committee on Government Reform
Subcommittee on Human Rights and Wellness
September 18

Passing the Feasibility Test: A Low-Income and Catastrophic Medicare Drug Benefit

Thank you, Mr. Chairman for inviting me. I am very grateful for the opportunity to testify this morning. My name is Jeff Lemieux, and I am the senior economist with the Progressive Policy Institute (PPI) and the executive director for a small new think tank called Centrists.Org .

Background. Before I joined PPI, I was the staff economist for the Breaux-Thomas Medicare Commission in 1998 and 1999.

The Medicare Commission made a simple, but profound proposal: Before considering benefit cuts or tax increases, we should try to slow the growth of Medicare spending through competition and consumer choice.

The Breaux-Thomas competition proposal used the Federal Employees Health Benefits (FEHB) system as a model. This plan was also called "premium support." The Medicare Commission's work resulted in the Breaux-Frist Medicare reform bill, which was first introduced in 1999.

Slouching Toward Reform. I have a great deal of respect for the members and staffers who have worked extremely hard to figure out ways to ease Medicare toward a premium support system. That is very valuable work that will almost certainly be important in the near future.

Moreover, PPI still believes that premium support will ultimately be the best way to reform the Medicare program toward greater competitiveness and cost-savings, benefit flexibility, and clinical improvements.

However, I now believe this is not the right legislation and now is not the right time to enact even a slowly phased-in premium support system. (The House-passed Medicare bill would begin to phase in premium support formulas in 2010.)

Medicare reforms based on competition should be preceded by an extensive national discussion, with full public debate on the pros and cons. Presidential leadership would be required to create that discussion.

I am worried that half measures, put together as a compromise in the conference committee, and not thoroughly considered and evaluated by the public, could actually discredit the larger reform concept. For example, the public might confuse "Medicare

reform" with the drug benefit that is included in both the House- and Senate-passed Medicare bills. The drug benefit is scheduled for implementation in 2006, and it is unlikely to work satisfactorily. Therefore, people might assume Medicare reform had failed (when in fact it hadn't been tried.)

An Unworkable Drug Benefit. The design of the 2006 drug benefit pending in conference was a rare political compromise. However, the result is a tortured policy, which would be very hard to implement. This is a recurring problem in health: reasonable sounding political compromises that may not be good policy.

Problem #1: The Premium. On a political level, it seems perfectly fair to ask seniors to pay a part of the cost of any large new benefit. But a premium of $35 a month (and rising over time) forces each senior to make a choice: Is the benefit worth the premium?

Clearly, seniors with high drug expenses will select the new benefit. To them, the premium would be well worth it. However, seniors with low drug expenses may not see the need. The problem is, if seniors with high drug expenses enroll, and seniors with low costs do not, the premium would be forced higher and the whole benefit could unravel.

To compel most seniors to enroll -- not just those with high drug expenses -- Medicare would impose a penalty: Seniors choosing not to purchase the drug benefit at their first opportunity would pay a significantly higher premium if they tried to enroll later. But this penalty will cause both confusion and resentment among seniors with little need for additional drug benefits.

Problem #2 The Cost. To hold federal outlays to the budgeted $400 billion over 10 years, the benefits are capped: Above the benefit cap, there would be no coverage -- this is the so-called doughnut hole in the benefit. To ease concerns about the cap, Congress added "catastrophic" coverage for seniors whose out-of-pocket drug spending exceeded about $3,500 in a year.

But this particular type of catastrophic coverage would not allow retiree drug benefits from seniors' ex-employers to count toward the Medicare benefit. That exclusion, in turn, gives firms an incentive to drop their retiree drug benefits. Why provide a retiree benefit that doesn't count?

The Congressional Budget Office estimates that employers will cease drug coverage for between 32 percent and 37 percent of their retirees. Other analysts say the number would be lower, at least at first. On the one hand, Medicare would provide subsidies to firms that don't drop retiree coverage. But with the federal budget already in deep deficit, those subsidies may not last. In any event, many seniors with retiree coverage would risk seeing that coverage dropped or reduced.

The decisions to raise the premium, carve up the benefit, and disqualify retiree coverage were made to satisfy a budget constraint. I realize that Congress wanted to preserve the

appearance of a standard, generous drug program, which seniors have come to expect. But to keep the federal cost within the budget, they had to nip and tuck.

A Feasible Solution: The Discount Card Approach. Mr. Chairman, I'd like to congratulate you for working on a zero-premium, low-income, and catastrophic drug benefit, which could be implemented as an extension of the Medicare-endorsed discount card approach already agreed to by the Medicare conferees.

The discount card approach would be both politically feasible and workable in practice. Moreover, it would be compatible with future competitive reforms. Finally, it wouldn't promise a more elaborate benefit than the budget can provide.

The discount card program is now scheduled to be implemented in 2004 as an "interim" measure. The discount cards would be available to all seniors for at most a nominal fee. They would provide discounts of roughly 10-20 percent off the retail price of many drugs.

In addition, low-income seniors could apply for extra assistance through the cards. The cards would provide up to $600 in benefits to seniors with incomes below 135 percent of poverty. The benefits would have a 5 percent copayment requirement for seniors under 100 percent of poverty (10 percent for seniors between 100 and 135 percent of poverty).

These low-income benefits would be added to seniors' discount cards in advance, like a cash card or a Medical Savings Account (MSA).

Instead of switching from the discount cards to a complicated, premium-based drug benefit in 2006, the cards' low-income assistance should be improved by increasing the poverty thresholds and raising the amount of benefits available on the card. Second, a catastrophic benefit should be added for all seniors through the cards.

Fairness to Seniors Who Do the Right Thing. It is wrong to try to target Medicare benefits to people who don't already have drug coverage, for several reasons:

1. Seniors could drop their current coverage to qualify for the new government benefits;
2. Seniors' ex-employers could drop their retiree coverage;
3. It would turn Medicare into a welfare program, not a social insurance program; and
4. It would reward people who never tried to acquire coverage on their own, while penalizing those who did the right thing and tried to protect themselves.

It is more expensive to allow all seniors with low-incomes to qualify for extra assistance, not just those who are currently uninsured. To keep the costs down, the poverty levels may need to be lowered, or the benefit amounts reduced. However, this is worth it, if it preserves incentives for seniors to take care of themselves, rather than creating a welfare-like program where seniors are rewarded for behaving less responsibly.

Catastrophic Coverage for All. I believe social insurance programs should have benefits that are appropriate and fair for all beneficiaries, rich or poor. Certainly catastrophic coverage for the highest drug costs falls into the category of coverage we want all seniors to have, regardless of income.

Moreover, catastrophic coverage for all Medicare beneficiaries would help the program target disease management programs to people with chronic illnesses, and could help Medicare's program for private health plan choices -- now called Medicare +Choice -- work better.

The Right Kind of Catastrophic Coverage. There are two kinds of catastrophic drug benefits: (1) coverage that begins when a senior's "out-of-pocket" drug spending hits a certain limit, and (2) coverage that begins when a senior's "total" drug spending hits a limit, regardless of whether or not the senior had additional drug coverage (from an ex-employer or Medigap plan, for example).

The second type of coverage -- based on a senior's total drug spending -- is preferable, because it would create the right incentives. It would reward people for working to obtain retiree coverage, or saving to be able to afford Medigap coverage. Their efforts would "count" toward the Medicare benefit.

On the other hand, a catastrophic benefit based on out-of-pocket spending would not maintain incentives for seniors to take care of their own coverage. And in the long run, it would not be much less expensive. Over time, seniors and employers would adjust to a catastrophic benefit based on out-of-pocket spending by dropping their outside or retiree coverage, making that sort of benefit almost as expensive as a benefit based on total spending.

A Multitude of Discount Card Issuers. The discount cards should be issued by as many qualified entities as possible: employers with retiree benefits, states, pharmacies, drug companies, pharmaceutical benefit managers, HMOs, and other health plans. This would create a healthy competition, in which card issuers competed to get the best discounts and services for their enrollees.

To reimburse for the low-income and catastrophic benefits, Medicare would pre-arrange performance incentives and accountability measures with qualified card issuers. These expenses would be Medicare's responsibility, and Medicare would audit the card issuers to ensure they were achieving sufficient discounts for seniors and were administering the catastrophic or low-income benefits in an efficient manner.

Conclusion. The main problem with the House- and Senate-passed drug benefits is that they overpromise. It would be better to enact a more modest expansion of the discount card program, adding benefits for low-income seniors and extending basic catastrophic coverage to all. The larger, more complicated drug benefit designs in the House and Senate bills may seem more politically palatable now, but they would likely be very unpopular or expensive if the government tried to implement them in 2006.

Likewise, it would be better to resume the larger debate about Medicare reform at a later date than to allow the reform issue to create an impasse on drug benefits or allow half measures toward reform -- which the public might not sufficiently understand -- to discredit reform concepts before they get a proper chance.

Mr. Chairman, I would be happy to try to assist your continuing efforts toward an alternative Medicare drug proposal, and to answer any questions you may have.

Mr. BURTON. Thank you, Mr. Lemeiux.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman, for inviting me to testify today as director of health policy studies at the CATO Institute.

Just following up on what Jeff said, I think with Congress in charge there is no danger of privatizing too much here. Current proposals to create a Medicare prescription drug benefit do too little to reform the overall Medicare program to improve the value of the services that beneficiaries receive, they also do too little to protect current and future taxpayers from runaway budget costs, and too little to target affordable and sustainable benefits to those low-income seniors most in need.

An MSA-like benefit tied to a catastrophic insurance policy that was delivered through private sector competition with beneficiary choice and targeted to seniors with the lowest incomes and the largest drug expenses could provide a more cost-effective solution. However, such a benefit must be structured properly, with features that reduce the inherent dangers of Federal price controls, over regulation of private plan options, and escalating costs, and also with features that improve incentives to maximize value by allowing funds and individual accounts to be portable, personally controlled property they can roll over each year without penalties.

In brief, the two bills providing a Medicare prescription drug benefit that were approved by the House and Senate earlier this year squandered scarce resources by focusing on subsidizing the discretionary, early dollar drug expenses of upper- and middle-income seniors.

H.R. 1 and S. 1 also failed to provide a credible and effective route to comprehensive market-based reform of the overall Medicare program. That kind of reform would expand the availability of a wider range of competitive benefits, affordable choices of drug benefits within integrated packages of linked benefits that provide the greatest value by coordinating tradeoffs between various treatment options. Absent sustainable, serious reform provisions within whatever is likely to emerge, finally, kicking and screaming from a House and Senate conference committee later this fall, a better alternative would be to do more by doing less. A far simpler combination of a limited drug discount card, additional financial assistance to low-income seniors, and a very modest catastrophic coverage benefit would solve the key problems of access to necessary drugs. It also would avoid causing further damage to future Medicare reform efforts, to our overall health care system, and to the deteriorating balance between our available resources and the increasingly overstretched commitments to capture more of them within the Federal budget.

In pursuing the alternative of a more narrowly targeted interim drug benefit with second-best limits and safeguards against the political dangers even it may pose, we should be careful not to undermine market-based incentives to control catastrophic level drug costs as well. Instead of providing relatively open-ended subsidies for such protection and delegating key financial and administrative decisions to Medicare program managers, we should instead place direct control, direct control of subsidized dollars for limited drug coverage in the hands of the eligible Medicare beneficiaries and

then, through open competition, encourage at-risk private insurers to offer higher value catastrophic protection to them.

An MSA-like account, combined with private catastrophic level protection against high cost along with the price protection of negotiated rates for expenses below deductible and stop-loss levels, could provide the vehicle for eligible seniors to receive and accumulate funds to afford better both the purchase of catastrophic insurance and essential out-of-pocket spending for prescription drugs.

Now beneficiaries spending more of their own money could also adjust the initial shell of such coverage to provide more customized options. Initial deductible limits also could be adjusted to target additional layers of subsidized coverage to those seniors facing the most difficult medical and financial challenges.

But this skewed nature of drug spending among Medicare seniors means that nearly one-third of all out-of-pocket drug spending will be incurred by the 5 percent of beneficiaries with annual out-of-pocket expenditures above $4,000. Subsidizing the early dollar drug purchases of most Medicare beneficiaries instead would leave fewer funds available to assist other more financially stressed seniors with multiple chronic conditions that require more expensive, longer term drug therapy. So we need to walk more slowly and carefully instead of racing ahead blindly.

The fundamental solution, of course, is to reform the overall Medicare program and allow seniors to determine the best uses of the taxpayer subsidies dedicated to them. It may well be the best we can do at the moment is to provide limited assistance to those seniors with the greatest drug expenses, along with more limited financial protection for uninsured seniors who otherwise would face the highest list prices for drugs when they purchase them on an out-of-pocket basis.

Thank you.

[The prepared statement of Mr. Miller follows:]

Testimony of

Tom Miller

Director of Health Policy Studies

Cato Institute

Before the

House Government Reform Subcommittee on Human Rights and Wellness

on

A Medicare Prescription Drug Safety Net:

Creating A Targeted Benefit for Low-Income Seniors

September 16, 2003

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Tom Miller. I am director of health policy studies at the Cato Institute. It is a pleasure to appear before you today to examine whether current proposals to create a Medicare prescription drug benefit do enough to address the needs of low-income seniors and whether an MSA-like benefit tied to a catastrophic insurance policy and targeted to low-income and indigent seniors would be a more cost effective solution.

In brief, both H.R. 1 and S. 1, the two bills providing a Medicare prescription drug benefit that were approved by the House and Senate, respectively, earlier this year failed to target their assistance to those seniors in greatest need. Both bills squandered scarce resources by focusing on subsidizing the discretionary, early-dollar drug expenses of upper- and middle-income seniors.

H.R. 1 and S. 1 also failed to provide a credible and effective route to comprehensive, market-based reform of the overall Medicare program. Such reform would expand the availability of a wider variety of competitive, affordable choices of drug benefits within integrated packages of linked benefits that would provide the greatest value by coordinating tradeoffs between drugs, surgery, hospitalization, and outpatient care options.

In the absence of serious, sustainable reform provisions within whatever is likely to emerge, finally, from the current House-Senate conference committee later this fall, a better alternative would be to do more by doing less. A far simpler combination of a limited drug-discount card, additional financial assistance to low-income seniors, and a very modest catastrophic-coverage benefit delivered by competing private sector entities actually would solve the key problems of access to necessary drugs. It also would avoid causing further damage to future Medicare reform efforts, to our overall health care system, and to the deteriorating balance between our available resources and the increasingly overstretched commitments to capture more of them within the federal budget.

In pursuing the alternative of a more narrowly targeted interim drug benefit with second-best limits and safeguards against the political dangers even it may pose, we should be careful not to undermine market-based incentives to control catastrophic-level drug costs. Instead of providing relatively open-ended subsidies for such protection and delegating key financial and administrative decisions to Medicare program managers, we should instead place direct control of subsidized dollars for limited drug coverage in the hands of eligible Medicare beneficiaries and then, through

open competition, encourage at-risk private insurers to offer higher-value catastrophic protection to them.

An MSA-like account could provide the vehicle for eligible seniors to receive and accumulate funds to afford both the purchase of catastrophic insurance and essential out-of-pocket spending for prescription drugs.

In most private insurance options, the price protection of negotiated rates could be passed down to out-of-pocket purchases remaining below the catastrophic stop-loss level. Straightforward high deductibles are administratively simpler and provide better economizing incentives than multiple tiers of coinsurance rates and co-payments. Beneficiaries spending more of their own money, of course, could adjust the initial shell of such coverage to provide more customized options. Initial deductible limits also could be adjusted to target additional layers of subsidized insurance coverage to those seniors facing the most difficult medical and financial challenges.

We should retain a sense of perspective in the midst of a too-often overheated Medicare drug-benefit debate. More than two-thirds of all Medicare seniors currently have some version of prescription drug coverage, and perhaps as many as three-fourths of them do under the broadest definitions of "coverage." Average out-of-pocket drug spending costs for all

Medicare beneficiaries this year is estimated to be about $1000. But the skewed nature of drug spending among Medicare seniors also means that nearly one-third of all out-of-pocket drug spending will be incurred by a much smaller number of beneficiaries – the 5 percent of beneficiaries with annual out-of-pocket expenditures above $4000. Subsidizing the early-dollar drug purchases of most Medicare beneficiaries would leave fewer funds available to assist other, more financially stressed seniors with multiple chronic conditions that require more expensive, longer-term drug therapy.

The sustainability of the overall Medicare program, as well as the future quality of life for younger workers and their families, remains at stake, too. Non-seniors need to finance their own health insurance, educate their children, and save for retirement. In addition, a generous Medicare drug benefit that overreaches available financial resources will surely trigger broader government price controls on drug makers and threaten to choke of access to the vast sums of capital and skilled manpower needed for the next round of lifesaving drug research and development.

In short, we need to walk more slowly and carefully instead of racing ahead blindly. The fundamental solution is to reform the overall Medicare program and allow seniors to determine the best uses of the taxpayer

subsidies dedicated to them. Until politicians decide to step up to that task, it may well be that the best we can do is provide limited assistance to those seniors with the greatest drug expenses, along with more limited financial protection for uninsured seniors who otherwise would face the highest list prices for drugs when they purchase them on an out-of-pocket basis.

Mr. BURTON. Thank you, Mr. Miller.

Mr. Antos.

Mr. ANTOS. Thank you, Mr. Chairman. Being the cleanup hitter, I probably will repeat some of the things that my colleagues have already said. But I want to say, Mr. Chairman, that I agree with you that a carefully designed drug benefit targeted on those most in need could be a very good investment of taxpayer dollars. But we have to be very careful about exactly what that design means and what we are doing with the rest of the program.

I want to emphasize two points. First, full consumer choice and active and strong competition among health plans are necessary to assure that beneficiaries receive the best value from a Medicare prescription drug benefit, or, indeed, the best value from Medicare as a program on the whole. Second, a targeted drug benefit is likely, no matter what we try to do, to mushroom into an expensive entitlement within a few years through future legislative expansions. I think it is virtually inevitable. Just look at the history. To ensure that the Medicare program will be able to accommodate future fiscal shocks, including shocks associated with Congress realizing they need to cut the budget generally, and cut the Medicare budget, in particular, any prescription drug proposal should contain at least a few elements that can form the basis for future reforms, not be the future reforms but a few elements that could be the basis.

I am strongly supportive of your general structure, Mr. Chairman, and Mr. Dooley's structure as well. I agree that having a medical savings account approach puts the incentives where they belong. Beneficiaries knowing that they have their own money to spend on drugs would tend to ask that all important question, should I go with the generic or not? They will ask the question, the pharmacist will not have to. So I think that is a very important and good feature.

But as you know, you have struggled with this yourself in your own bill, setting the levels of subsidy and setting the catastrophic stop-loss level and so on, these decisions are very, very difficult to get right, so to speak, especially if we are trying to stay within budget limits. Your bill takes several additional steps to try to stay within the limits, including restricting the eligibility to the benefit to individuals who are both low-income and do not have access to other kinds of prescription drug coverage, regardless of what that coverage might be. You also have a budget cap, and you also adopt a very regulatory approach for managing the benefit.

I am not going to say too much about eligibility. I would be concerned though that being able to actually implement and eligibility rule that went beyond income I think would be very difficult. The absence of something typically does not leave a trace, a paper trail. So I think that is going to be a real difficult problem.

The budget cap. I know you have been worried about the budget for years. Most of us have been worried about the budget for years. I think we should admit that budget caps do not work. They have not worked in the past. It is unlikely that they will work in the future. The fact is that nothing can stop a future Congress from enacting legislation that would blow the cap. It is difficult to impose a strict cap. What it means in the case of your bill is to reduce the

value of the benefit to low-income people. That is very difficult politically, and especially if those reductions look like they have to take place year after year, which I think we would all agree would likely be the case.

But let me turn to this question of competition and Government control. I believe that the best solution to the cost problem is to harness the forces of competition. This strategy has worked well for at least a decade in private insurance with documented savings of 35 percent or more when pharmacy benefit managers have been permitted in the private sector to use their cost management tools aggressively.

Your proposal and other proposals like it take a more regulatory approach. You would have private entities participate in this but only in the way that Part B carriers participate in the Medicare program today. They do not function as independent health plans, they pay bills, they do not make decisions, or at least some think they should not make as many decisions as they actually do, and they have little or no financial interest in keeping costs down. As Mr. Haislmaier said earlier, negotiations really in this case is going to be a rate-setting exercise, very much like the physician payment fee schedule that we have today except expanded by far because we are talking about thousands of prices. It is a much bigger deal here. And however the prices are set the first year, after that we would almost certainly see an inflation factor that would be ratcheted up. Congress would, of course, go through the usual budget games of having lower updates like we do with hospital payment and physician payment as well. Negotiations would occur, but they would be very limited and they would be necessary primarily when a new drug appeared on the market, or tried to appear on the market. The Secretary of HHS would be able to withhold access to any new pharmaceutical, which is obviously an extremely powerful threat that could lead to low prices for new drugs under Medicare, if the new drugs actually emerge.

There are some really bad side effects, however, to this policy. First of all, if we do have a rigid structure, as under physician payment, and I know that your bill does not say this but I think it is virtually inevitable, then one of the bad things is that generics will no longer be a competitive factor in forcing prices down for name brand drugs. There is a lot of price competition now in the market associated with generic drugs and associated with branded drugs that have similar therapeutic values but different chemicals. Delaying the entry of a drug to a Federal formulary could harm patients. And the threat of low launch prices would inevitably deter research and development for potentially valuable or life-saving drugs, particularly those that treat illnesses associated with older age groups.

So you can have some immediate budget savings, and they are very attractive—I agree with you, they are very attractive—but the long term consequences are serious, they are virtually permanent, and we will never really know, again, there is no paper trail if a drug does not show up, we do not know what could have existed. But we do know that this would discourage research and development that could lead to more effective therapies that could actually

reduce costs in the rest of Medicare. I think it is a very serious problem.

I think we need to be very careful about other provisions. The whole idea of having the Government absorb the full financial risk of insurance at any level inevitably means, even under the Dooley bill, that there will be a Federal fee schedule for drugs. How else can the Government compensate drug plans, even under the Dooley bill, for their costs if they do not have a price upon which to base the payment. It is a real problem.

I think we need to be very careful about this. But I think there is an opportunity here to do some very good things for beneficiaries and for the program. Thank you.

[The prepared statement of Mr. Antos follows:]

A Medicare Prescription Drug Safety Net: Creating a Targeted Benefit for Low-Income Seniors

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Wilson H. Taylor Scholar
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The American Enterprise Institute

Testimony Before

Subcommittee on Human Rights and Wellness
Committee on Government Reform
U.S. House of Representatives

September 18, 2003

Mr. Chairman and Members of the Committee: Thank you for inviting me to appear before you. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. I am also adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill. I have previously served as the assistant director for health and human resources at the Congressional Budget Office (CBO), and earlier held several research and management positions in the Health Care Financing Administration, the precursor to the Centers for Medicare and Medicaid Services (CMS). The views I present today are my own and do not represent the position of the institutions with which I am associated.

The chances of hammering out an agreement on reforming Medicare and providing a prescription drug benefit to 40 million seniors and disabled people seem to diminish every day. Democrats maintain that the prescription drug benefit is just not good enough, while Republicans raise the specter of program meltdown if we spend too much. Republicans see the promise of lower cost and better performance through competing health plans, while Democrats fear that competition will jeopardize the traditional Medicare program and harm millions of beneficiaries.

There has been growing speculation in the press that the Medicare conference will not be able to reach a compromise and will need an exit strategy. That strategy could focus on the needs of low-income beneficiaries—those with no prescription drug coverage, some of whom have very high drug costs. A carefully designed drug benefit targeted on those most in need could be a very good investment of taxpayer dollars. But such a program could be as controversial as the bills that are currently under consideration.

Chairman Burton has developed the Medicare Safety Net Prescription Drug Act, which provides a drug benefit to low-income beneficiaries. In broad terms, the proposal is similar to other targeted benefit approaches. Beneficiaries would have access to discounted drug prices, their purchases would be subsidized through a personal account accessible by a debit card, and catastrophic insurance would be provided. The benefit would not be open to all Medicare beneficiaries, and federal outlays would be capped. The proposal is limited to a drug benefit, and does not include broader reform measures.

The Chairman's proposal has several desirable features but also significant flaws that are shared by other similar proposals. My testimony will address those design aspects and suggest other approaches that could be more effective in reaching policy goals.

Two key points emerge. First, full consumer choice and strong competition among health plans are necessary to assure that beneficiaries receive the best value from a Medicare prescription drug benefit. Second, a targeted drug benefit is likely to mushroom into an expensive entitlement within a few years through future legislative expansions. To ensure that the Medicare program will be able to accommodate future fiscal shocks, any prescription drug proposal should include elements that can form the basis for future reforms.

Designing a Low-Income Drug Benefit

The first principle in designing a Medicare prescription drug benefit is that someone will be

unhappy, no matter what you do. The plethora of competing, and often contradictory, policy objectives cannot all be satisfied. For example, the House and Senate bills carve a "doughnut hole" out of the middle of the drug benefit, not because that is good policy but to keep the CBO cost estimate down to $400 billion. This budgetary legerdemain results in a peculiar kind of drug benefit that some have labeled unfair to the poor. However, everyone eligible for Medicare would participate. The bills' sponsors struck a balance between benefit generosity, budget cost, and beneficiary participation that others would dispute. A narrower proposal like the Burton bill shifts that balance—creating new winners and losers among beneficiaries, gaining some votes and losing others in Congress.

I will focus on five major design features of the Burton proposal: eligibility, benefit structure, benefit administration and competition, the budget cap, and prescription drug reimportation. Although the proposal contains some innovative elements, it does not stray far from the regulatory model of traditional Medicare. Other proposals, including variants of the bill proposed earlier this year by Congressman Cal Dooley (D-Cal.), are more promising but also fall short of the mark.

Eligibility

More than three-quarters of Medicare beneficiaries have some prescription drug coverage (see Table 1). Perhaps surprisingly, that is true at all income levels. Lower-income people are more likely to have coverage through Medicaid, while higher-income people primarily have private coverage (see Table 2).

Proposals for unrestricted eligibility for a Medicare drug benefit, such as the House bill, would displace much of the existing coverage and substitute federal taxpayer dollars for other funds that are now being spent. The Senate bill excludes people (the "full duals") who are eligible for both Medicare and full Medicaid benefits from the Medicare benefit. That reduces federal outlays (which the Senate bill spends elsewhere), but leaves states with a growing liability.

A targeted benefit gives larger subsidies to low-income beneficiaries, rather than distributing that money to everyone. The Burton proposal goes further, limiting the benefit to those who are not eligible for any other prescription drug coverage. If it could be implemented, that would be a stronger restriction than excluding those who are enrolled in some other drug benefit.

It is possible to verify the incomes of most beneficiaries through income tax forms. But it is extremely difficult to determine if someone does not have prescription drug coverage and is not eligible for such coverage from some source. The absence of insurance does not leave a paper trail.

Table 1. Prescription Drug Coverage of Medicare Beneficiaries by Poverty Level, 2000

% Of Federal Poverty Level	% of Medicare Beneficiaries	% With Rx Coverage
Less than 100%	24%	77%
100% to 199%	31%	75%
200% to 299%	19%	82%
300% or higher	26%	81%
All income levels	100%	79%

Note: Includes only Medicare beneficiaries living in the community.

Source: Tabulations of the Medicare Current Beneficiary Survey from Becky Briesacher, University of Maryland.

Table 2. Sources of Prescription Drug Coverage for Medicare Beneficiaries by Poverty Level, 2000

% Of Federal Poverty Level	Employer-Sponsored	Medigap	Medicare HMO	Medicaid	Other Public
Less than 100%	12%	7%	13%	42%	10%
100% to 199%	28%	12%	19%	9%	8%
200% to 299%	45%	14%	20%	2%	4%
300% or higher	49%	15%	14%	1%	4%

Note: Beneficiaries may have more than one source of coverage. Includes only Medicare beneficiaries living in the community.

Source: Tabulations of the Medicare Current Beneficiary Survey from Becky Briesacher, University of Maryland.

Even if we could enforce such eligibility restrictions, we might not want to. Some people may be eligible for private coverage but cannot afford to participate. Others may have limited coverage that provides no catastrophic protection. Some people with incomes too high to qualify for the Burton program might have high prescription drug expenses and no coverage. Future Congresses would be tempted to loosen the eligibility limits to accommodate many of those people, just as they would be tempted to expand benefits and fill the doughnut hole under the Senate and House proposals.

Benefit Structure

The House and Senate bills offer traditional first-dollar coverage for prescription drugs. After a modest deductible ($250 in H.R. 1 and $275 in S. 1), beneficiaries would have a significant fraction (80 percent in H.R. 1 and 50 percent in S. 1) of their prescription drug costs paid by the government. This is a use-it-or-lose-it benefit, and enrollees will have a powerful incentive to use it after they've paid $420 or more in annual premiums.

The Burton proposal changes that incentive. Instead of first-dollar insurance coverage, beneficiaries would be required to pay a high deductible (perhaps $3,000) before catastrophic insurance covers their prescription drug expenses. To help them pay the deductible, beneficiaries would be given a cash subsidy paid into individual accounts and accessible using a debit card. Under this approach, beneficiaries would be sensitive to prescription drug costs and still be protected financially. Beneficiaries would use their own money (from their accounts and out-of-pocket payments) to pay for drugs until they met the deductible. Any amount left in their accounts would roll over for use in the next year.

The drug account would not become a permanent asset for beneficiaries, however. If an enrollee lost eligibility for the benefit or passed away, his cash balance would revert to the Treasury. Although that may seem fiscally prudent, it undercuts the beneficiary's incentive to limit unnecessary spending. Beneficiaries might not be as diligent in selecting lower-cost pharmaceuticals if they felt that the account balance could be taken away at any time.

Benefit Administration and Competition

The prescription drug benefit under the Burton proposal would operate much like a Part B benefit. That is, a division of the U.S. Department of Health and Human Services (HHS) would determine what drugs would be covered, set their prices, certify participating pharmacies, determine the eligibility and level of subsidy available to beneficiaries, establish the personal drug accounts, and issue the debit card. Private entities would be contracted to handle administrative functions and pay the bills, just as large insurance companies acting as Part B carriers do today.

The proposal asserts that the Secretary of HHS would negotiate pharmaceutical prices, but those negotiations would quickly become rate setting exercises similar to the way physician fees are set. It is clear that any negotiations that did occur would be the exception rather than the

rule. Since Medicare beneficiaries use every available pharmaceutical, that means negotiating tens of thousands of prices for products in every dosage form, strength, and packaging. Prices for drugs would be set in an unspecified manner the first year. Almost certainly, HHS would establish an inflation factor that would ratchet up the entire price structure in subsequent years.

Negotiations would be necessary whenever a new drug appeared on the market. The Secretary would be able to withhold access to any new pharmaceutical, a powerful threat that could lead to low prices for new drugs under Medicare. However, there are bad side effects with this policy prescription:

- Competition from generics and therapeutically similar drugs would no longer force down prices of branded drugs under a rigid federal price structure.

- Delaying the entry of a new drug onto the federal formulary would be politically difficult and could hurt some patients.

- If Medicare set prescription prices at very low levels, manufacturers are likely to raise prices to private purchasers, including most people under age 65. The proposal includes a reimportation provision, discussed below, to limit that possibility.

- The threat of a low launch price would deter the research and development of potentially valuable or life-saving drugs, particularly those that treat illnesses associated with older age groups.

The budget savings from top-down regulation are immediate and seductive. But the consequences of such an approach are long-term and serious, discouraging the research and development that could lead to more effective and potentially cost-saving drug therapies. Even in the near term, lower prices for Medicare could mean higher prices for everyone else.

A competitive approach can strike a better balance between lowering prices and promoting innovation. This is the conceptual basis of the House prescription drug provisions, and it relies on the proven ability of competing private plans to negotiate substantial discounts and manage the cost of the benefit.

If private drug plans are placed at risk for the cost of providing prescription drugs to their Medicare enrollees, they have a strong incentive to limit cost growth. The plans can act on that incentive if they are given the flexibility to manage the benefit aggressively. With a wide choice of plans, beneficiaries will be able to select a plan that meets their needs—and change plans if they are dissatisfied.

A number of proposals, including the Medicare Rx Now Act proposed this year by Congressman Dooley and the Medicare Rx Drug Discount and Security Act proposed last year by Senator Chuck Hagel (R-Neb.), rely on private plans to deliver a benefit structured like that of Chairman Burton's bill. The earlier proposals would make drug benefits available to all Medicare beneficiaries, rather than targeting those with low incomes. They merit discussion

because they use a modified form of plan competition.

The Dooley and Hagel bills would offer the new benefit through many competing plans, but those plans would not be liable for excess costs for beneficiaries who exceed the catastrophic spending limit. Instead, the federal government would pay all costs of catastrophic coverage on a fee-for-service basis.

Although that might seem to be a reasonable split of private and federal responsibilities, such an approach is a short step from the situation posed by the Burton bill. The federal government could pay whatever each plan asked, but then some plans would be paid more than others for the same prescription drug purchases. To prevent unfairness and potential fraud, HHS would probably establish a federal price list for all pharmaceuticals. Reimbursement based on federal, rather than actual, prices would potentially ignore real cost differences faced by the private plans. The likely result would be an increasingly complex pricing system, as the price schedule is modified to take account of special circumstances. If federal prices lagged behind actual prices (likely if Congress faces budget pressures and holds down Medicare reimbursements), private plans would drop out of the program and the demand for a fully federalized system might be irresistible to policymakers.

An alternative approach would solve many of the problems posed by proposals like the Dooley bill. First, the restrictions on how private plans could manage their drug benefit should be relaxed. The Dooley bill assumes that many kinds of plans would participate, including employer-sponsored retiree plans. However, the regulatory requirements imposed on such plans would force such plans to revamp their benefits and methods of operation, making participation in Medicare impractical at best. Second, plans should be placed at financial risk for the catastrophic insurance benefit. To assure a stable system and encourage plan participation, a national reinsurance pool run by the participating plans could be organized for all Medicare drug plans. Such a pool would spread excess costs among all beneficiaries, eliminating the incentive to avoid enrolling sicker seniors. Premiums would include the cost of those high expenses averaged over all Medicare beneficiaries. That would protect private plans from the problems of adverse selection and provide greater incentive for plans to participate in the program. This arrangement would offer the advantages of a national risk pool without the threat of price controls and limits on beneficiary choice posed by fully federalized benefits.

Budget Cap

The prescription drug benefits proposed in the House and Senate bills are open-ended entitlements and are likely to cost far more than $400 billion by 2013. CBO has produced its best estimate of federal outlays, but the likelihood of higher spending is greater than the reverse. Moreover, political pressure to fill the doughnut hole in the benefit is likely to be irresistible, and future benefit expansions could easily double the level of actual outlays.

The Burton proposal includes a hard cap on spending in the hope of preventing higher outlays resulting from either estimating errors or legislative action. If spending was projected to

exceed the cap, the Secretary would increase the catastrophic coverage threshold or reduce the federal subsidies provided through the prescription drug accounts.

Spending caps do not work. Nothing can prevent a future Congress from changing the law and wiping out the cap. If the cap was binding, that would reduce the value of the drug benefit to low-income people—a difficult situation to sustain politically, particularly if further reductions would be necessary year after year.

Medicare currently has a spending cap on physician payments called the sustainable growth rate. If physician spending rises above that growth rate, fees are to be reduced. In 2002, Medicare reduced physician fees by 5.4 percent across the board. That caused a reduction in access to physician services in some parts of the country and complaints from doctors everywhere. A further reduction was scheduled for 2003. In February, Congress modified the payment formula to give physicians an increase, and there is substantial sentiment for additional relief in future years.

This is a clear case in point. The sustainable growth rate was popular only when it was not acted upon. We can expect no more from a spending cap on prescription drugs. Rather than trying to control spending with caps, we should design a program that gives beneficiaries more control—and more personal responsibility—over their health care. Personal accounts and high deductible insurance provide some incentive for prudent purchasing, but other restrictions in the Burton bill limit their impact. More plan options and effective competition are needed if we expect to limit spending without limiting the value of the benefit.

Reimportation

The Burton bill would apply additional pressure on the pharmaceutical industry by authorizing the importing of drugs (often called reimportation). Importers who resell the drugs would be responsible for ensuring that the imported products are genuine and safe. This provision is intended to lower prices of drugs in the market generally, not just those dispensed under Medicare.

Supporters of a reimportation provision point out that U.S. residents pay the highest drug prices in the world, exceeding the prices found in Germany, France, and other developed countries. Those countries threaten to produce their own versions of branded drugs ("compulsory licensing") unless pharmaceutical manufacturers agree to sell products at very low prices. Since the cost of developing a drug is very high (perhaps as high as $800 million) and the cost of manufacturing it is usually fairly low, manufacturers are ahead in the short term as long as their costs of production are covered. Such prices would not compensate for the huge costs of research and development required to get a new drug to market, thus discouraging future research.

The U.S. government also negotiates low prices for prescription drugs, but those prices apply only to federal programs such as the Veterans Affairs health program. Reimportation is an indirect way of establishing price controls in the U.S. for all pharmaceuticals sold in all markets.

The problems with price controls were discussed above, and those comments apply in full to reimportation. The likely impact of reimportation may be disappointingly small, however. Middlemen are likely to absorb most of the price reduction that might be possible by importing drugs at a lower price. People with employer-sponsored health plans are unlikely to see reductions in their drug costs because such plans typically have multi-tiered copayment systems, and savings that might occur are likely to be retained by the employer. People without drug coverage stand to benefit more, but even in this case we should expect to see an uneven pattern of discounts rather than across-the-board reductions of any significant magnitude.

Conclusion

A targeted low-income benefit could be a feasible alternative if the Medicare conference stalls. Such a benefit would avoid displacing the good coverage that many beneficiaries now have and are fearful of losing. It could provide important financial support for people who need help the most—those with a limited ability to pay for their prescription drugs, those with high drug costs, those without insurance coverage. Combining a discount card, a cash subsidy in a personal account, and catastrophic insurance would provide some of the elements for a sensible benefit for millions of seniors.

It would be a mistake to create even a limited Medicare drug benefit that repeats the mistakes of the past. Attempts to limit federal cost by overall spending caps, price controls, and restrictions on beneficiaries and providers lead to worse health outcomes, and at best have only a temporary ability to hold down spending. Competition among drug plans, with flexibility to design their benefits and negotiate their best prices, will lead to more effective cost control. Proposals that give beneficiaries more purchasing power and more choice will result in better value and provide the basis for future improvements in the Medicare program.

Mr. BURTON. We have two votes on the floor. So I will be back in just a few minutes.

We stand in recess.

[Recess.]

Mr. BURTON. The subcommittee will be in session.

Let me start off by asking a general question. A number of you mentioned that you thought that there was going to be a problem with cost containment over the long term, putting caps on. Do you not think, and any of you can answer this, do you not think that if we went with medical savings accounts where people were having the money put into their account, people would husband that money very well, most of them, and would not spend it unless they really felt like they had to, and they would decide what product they should buy, what prescription they should buy, and shop around, which would have a dilatory effect on overall spending and could keep us within the caps? I think what you said was that the caps eventually were going to be breached. You do not think that even with the medical savings account we could keep control of the costs?

Mr. ANTOS. I do not think it is the seniors. Seniors are well known for watching how they spend their money. So I agree with you, I think an MSA-type of an approach makes a lot more sense than first dollar coverage. What I was really pointing to was future Congresses will have a hard time resisting the temptation to substantially expand the scope of the benefit in terms of who is eligible and in terms of the generosity of the subsidy. I think that is where the caps fall down. I really think that is the history that we have seen with, for example, the Gramm-Rudman-Hollings overall budget cap. I believe that what really happened was that spending priorities took over from deficit reduction priorities. And I really think that we would see a similar sort of situation in the Medicare program as well. But as far as the behavioral implications of giving people money that is theirs to spend, I think that is a very powerful incentive and it works the right way.

Mr. BURTON. That is probably one of the best cost containment tools we could use. And we could also use that in Medicare in general. I know you guys are all in favor of Medicare reform, complete Medicare reform, and this being a part of that. But the fact is we are not going to get to that enchilada this time. They are having enough trouble with just a prescription drug benefit and I do not see us doing any major revision.

Mr. MILLER. Mr. Chairman, if I may?

Mr. BURTON. Yes.

Mr. MILLER. We have a medical savings account plan at CATO Institute, so we are quite familiar with how it operates. But it would operate a little differently than what would be this targeted MSA account for just spending on drug benefits. Let us remember what the real MSA works like. It means that if you save your money, you actually get to get it back or keep it and use it for other things. You can pass it on to your heirs, eventually you can receive it as income, you can spend it on other types of health care. This is much more targeted so you already have an ingrained requirement that you better spend it on drugs. It is good that it stretches it beyond the 1-year use it or lose it perspective, so that gets you

part of the way. And even with the MSA account, you are still talking about most of the drug spending being at the catastrophic level. And since we are talking about structuring, this is in your bill a Government defined catastrophic benefit largely delivered through secondary administrators of what is, in effect, Government control. You are not getting the dynamics of the type of private sector variety which makes people be sensitive to those costs at the upper end as well as at the lower end.

Mr. BURTON. Well how would you change that?

Mr. MILLER. Well, if our hands are tied behind our backs without, in effect, reforming the rest of the Medicare program, I would say the first way you would change it is kind of have all the benefits on the table. So that is the reason why it is like you are in a box, you cannot do this, and that is why you are kind of doing it awkwardly.

A couple of points. One would be, if people are financially needy, if you want to determine that, you should give them money and let them determine what they need to spend their money on. They might need to spend their money on other types of health care, they might need some food, they might need some shelter. If they are over 65, they have other needs than just drug benefits. Let them decide that that cash you gave, because they are income needy, that cash is necessary for drug benefits. Give them the negotiated prices through private sector negotiators so they are not paying list prices, but they may determine they have a different set of priorities than what everyone else has determined you must spend it on prescription drugs regardless of anything else. Why not allow them to decide where they need to spend their money.

Mr. BURTON. You are preaching to the choir. I am with you 100 percent. I would like to go to medical savings accounts for everybody with government participation setting some parameters on them so that we could get control of the overall spending. Right now if somebody goes to the doctor and he says it is covered under your insurance or under Medicare, they say OK. But if it were their money, they would not do that. They would say do I really need to spend this. So, yes, I am for that. But as I said earlier, this is not likely to happen because we are having enough difficulty with this one facet right now.

One of the things that we have been working on, and I know that you all disagree with, is the reimportation of pharmaceutical products. I think a couple of you alluded to that in your remarks and indicated that there would be less research and development if you forced the pharmaceutical companies and the Government to allow for reimportation. I would just like to ask you a question. How do you explain to a senior citizen right now who lives in Minnesota, Indiana, Michigan, up along the border there, who have been buying their pharmaceuticals through the Internet, how do you explain to them why a product costs one-third in Canada what it does in the United States and why they should not buy it up there? It is OK to say, sure, research and development costs, and advertising costs, and everything else, and we are paying for that down here. But how do you tell them when they are dying of cancer and they need Tomoxifin, how do you tell them they have to pay five or six

times as much for it when they live on one side of the border than the other? Give me an answer to that one.

Mr. ANTOS. Of course, there is no good answer for that, Mr. Chairman.

Mr. BURTON. There is no answer.

Mr. ANTOS. But let me make the point that the real problem that we have is the usual myopia that everybody has—you can see what is in front of you, you cannot see what is ahead. In this case, it is a particularly serious and disturbing kind of a situation. What we can see in front of us is we have this product, Tomoxifin, we see the prices—you are more familiar with the prices of this drug than I am—and it is easy to make the comparison and say why am I paying more than somebody else. What we cannot see is the drug that does not exist now that pharmaceutical companies are working on now that they can turn around on a dime and decide it is not worth putting any more money into the development of that drug. So what we will not be able to see, because it will be the absence of something, we will not be able to see the real consequences in a way that the average person would say, oh, yes, that is right, we could have had drug X but it did not come down the road.

Mr. BURTON. I am for research and development. I am for the taxpayers paying for some research and development, as we have been doing to a large degree through HHS. We have been paying for an awful lot of this R&D and we have been giving all kinds of tax breaks. For instance, some of the pharmaceutical companies get all of the payroll that they expend in Puerto Rico deducted from their taxes under the 936 program simply because they are providing employment. The problem is they hire somebody and they work for them for 10 years and they get that salary written off year after year after year; it saves them millions of dollars. So there is a lot of benefits that they accrue that is not readily apparent.

What I would like to see is them spread the cost of R&D and advertising and everything else out in other areas, not just on the United States. Then the argument comes back, and I would like you to respond to it because you are the learned people, the argument comes back that, well, there are cost controls and price controls and there are negotiated prices in these other countries. Well, that is true to a degree. They use parallel pricing in Europe where they go across the border and get the best price and their costs are much lower as well. But if we really believe in free trade and free enterprise, why should we exempt pharmaceuticals alone. We import meat, we import fruits, we import vegetables, we import every other thing you could think of from Central and South America, from Mexico and Canada, but we cannot do it with things that save people's lives.

Now I understand what you are saying about the research and development. But why should Americans bear all that cost and why should it not be spread out among the others?

Mr. ANTOS. I think that is a very fair question. I think that is a question on the minds of most Americans today. And there is no easy answer to this. Clearly, the pharmaceutical companies could choose, in theory, to not sell one of their big products to a Germany or an England or a Canada. They could choose to do that as a way of giving those countries the strong message that we cannot sell at

that price any more. That would have been a great strategy on introduction, by the way. It is a much harder strategy if you have been selling the stuff for 5 years. But nonetheless, yes, it would be great if they would do that if they did not have an additional threat, and the threat is that at least some countries are well equipped to simply take over the published information about how to produce the drug. It is very simple to do.

Mr. BURTON. And go to generic and break the trade restrictions?

Mr. ANTOS. Yes. That is right. So if we view this as a trade issue, then the interesting question is where is the U.S. Government in all of this.

Mr. BURTON. Well we have the World Trade Organization, GATT, we have NAFTA, all these things that would be violated and there would be all kinds of litigation I am sure. And that is one of the things that maybe we are going to have to deal with because you cannot load all these profits and costs on the back of one segment of society.

One of the things that bothered me, and I do not want to lecture you guys because you are the experts and you work on this all the time, was when we had loans that we gave to Latin America and other parts of the world and they defaulted on those loans, and they had a very good interest rate, the banks were losing their shirts and it was never said to the American people you are going to pick up those costs with higher interest rates. But we did. The interest rates went up, the banks got well, the South American countries did not have to pay for their losses, we wrote those off and we wrote them off in other parts of the world, and the American people paid for it. There has to be a limit to that. And when you are talking about people's health, there has to be some balance. And the Think Tanks, like you folks, I would hope would try to come up with some kind of a solution. I have talked to a number of the pharmaceutical companies and some of their CEOs and said let us sit down together and try to work this out, let us find some solution. It is a Gordian knot, no doubt, but it is something that we need to sit down and try to work out so that the Americans are getting as close as possible a fair price for the products they are buying.

Did you have a comment?

Mr. HAISLMAIER. Mr. Chairman, if I could just make one comment. I certainly would agree with my colleagues on this, the best way to think of this really is that it is not a problem so much with the pharmaceutical companies because they are dealing with what is dealt them in many ways, it is a problem with other countries in effect cost-shifting their health system's cost onto us. You may recall the arguments a number of years ago about whether the private sector was cost-shifting to Medicare back in the 1970's, and then in the 1980's we had the argument that by putting on all these price controls in Medicare that Medicare was shifting costs onto the private sector. Well that is what is going on, it is just going on on a global scale. And specifically, it is not the majority of countries, it is not the Third World countries, really, it is the peer group of ours, the developed, industrialized western countries which have, by and large, national health systems and they are dictating these prices. And the reason they can do it there and shift

it onto us and the pharmaceutical companies simply go along with it is the difference in population. Their populations on an individual basis are smaller than ours. Canada is, what, 25 million people versus 280 million people. So the pharmaceutical company will say, all right, I can live with that, especially if the threat is that if I do not go along with it you are going to take away my patent and give it to somebody else to produce the drug.

So, yes, I think the solution is that we have to engage this on a government-to-government basis. I think that is vitally important, not just for drugs but for everything else. You can play the same game with our other industries in this country. Software. What happens to software in this country if other countries say give us the price we want for software or we will just take it away and copy it and the heck with your copyright laws.

Mr. BURTON. We fought that fight with Taiwan, China, and others on intellectual property rights.

Mr. HAISLMAIER. Right. But I think it is very important that we in this country understand that whether it is the entertainment industry, movies, singers, etc., or the software industry, or the pharmaceutical industry, more and more of our economy in this country is dependent on intellectual property rights and our whole economy is in trouble if we do not defend those rights and force other countries to recognize those.

Mr. BURTON. Well, you make my point.

Mr. HAISLMAIER. Yes. We are not that far off.

Mr. BURTON. You are making my point, and that is that our Government and the pharmaceutical companies combined ought to sit down together and say, OK, what are we going to do to protect the property rights, the patent rights, while at the same time making sure that we are protecting Americans' health and helping the rest of the world. With the Internet the way it is right now, I think it is a fait accomplis. I mean, if they stop selling pharmaceuticals in Canada, like some of the companies are doing, people are going to get on the Internet and buy them from Germany, France, Spain, or elsewhere. And the world population is pretty big, especially in the industrialized nations, it is not just us. So if you push in on one side of the balloon, it is going to pop out someplace else.

What I would like to see, and I do not know if the pharmaceutical companies are listening, they usually do not listen much to me, they just jump on me, but I would like to see them sit down and become a partner with the Government in negotiating and working out this solution so they can go ahead and do R&D, they can go ahead and make 16, 17, 18 percent a year profits, and they can expand and do the things they want to do. But it should not all be done and loaded on the back of the American people. My wife died of breast cancer. Fortunately, we had insurance. But there were women out there who could not get Tomoxifin, could not afford it because it was so costly and they did not have insurance, and right across the border in Canada they could get it for one-seventh of what it cost here. That is not right.

Mr. HAISLMAIER. Mr. Chairman, just since you brought that up, I wanted to followup on Joe Antos' comment. You have been around here a while and I think all of us on this panel remember the Medicare Catastrophic Act in 1988, you talked about it in your

opening statement, and I would simply make the point that if that bill had gone through and if you had had the kind of price controls on pharmaceuticals, your wife never would have had Tomoxifin because it would not have happened. The incentives to do that would have been taken away and that drug never would have happened.

Mr. BURTON. I voted against it.

Mr. HAISLMAIER. Yes, I know. You were right to.

Mr. BURTON. I voted against it for that reason and for a number of other reasons. But the point is that we are at a point now where we have to do something. We are talking about a prescription drug benefit and there is no negotiating in any of the bills that I have seen before the Congress. Which means, simply, that if we pass one of these bills as they are presently written, as the bill that passed the House, for instance, the Government cannot even negotiate prices with the pharmaceutical companies. They cannot do it. And so if they want to charge six times what it costs it Canada, or five times what it costs in Germany for a pharmaceutical product, the taxpayer is going to have to pay for that. It is going to cost a lot more. I think it is going to cost up to $5–$6 trillion if we pass it in the form it is.

So what we have to do is we have to say, OK, we want them to make a profit, we want there to be free enterprise, we do not want there to be cost controls, but there should not be a gouging of the American people to the extent of the rest of the world. And toward that end, there ought to be some negotiation. Now we do it with the Veterans Affairs right now. The VA negotiates prices with the pharmaceutical companies. We tried to get that information. They will not give it to us. Now I am going to get it, you can count on it. You know that I will get it. But the point is why is it that we can negotiate on veterans and we cannot for the rest of the population, especially our seniors.

Mr. HAISLMAIER. The answer is the VA does not negotiate. They more or less dictate. And they have another lever, correct me if I am wrong, but one of the levers is if you do not play ball with the VA, then you are not only out of the VA, you are out of Medicaid as well. So that was my point in the earlier remarks, is the Government does not negotiate the way private players negotiate, they always are holding a gun there.

The negotiation that I would see, and this gets back to the cost control, I think you are on the right track here. I think all of us agree, if you are giving beneficiaries the money and saying you make the choices in the private market, and I would argue in terms of the catastrophic insurance and not just the drugs, then you are going to see a whole bunch of agents involved in negotiating on their behalf—the pharmacy benefit managers, the insurance plans, etc.

Let me give you an example. The FEHBP, which presumably you and your wife were in, the Federal Employees Health Benefits Program, covers 9.5 million Federal workers and retirees. You pick your own plan and those are private plans. Now instead of the Government saying I have 9.5 million people here and I am going to "negotiate" prices for these 9.5 million people, what they do is they are allowed to choose their own plan. So let us say half a million people choose Aetna, but Aetna has millions of other subscribers,

so they are putting them together and negotiating. The same thing is going to happen with Medicare.

Mr. BURTON. Who does the negotiation for Aetna with the pharmaceutical companies?

Mr. HAISLMAIER. They probably have a pharmacy benefit manager. It is either in-house or——

Mr. MILLER. You can bring it in-house, Ed, actually.

Mr. HAISLMAIER. Yes. Well Point has an in-house one, some of them go with——

Mr. BURTON. I know. But the point is they negotiate with the pharmaceutical companies for the prices that they pay for the pharmaceuticals that they are giving to us at a discount.

Mr. HAISLMAIER. Right. Yes. And so the same thing would work in Medicare.

Mr. BURTON. I have no problem with whether it is an individual company doing it or if we do it through the Government, but there has to be some mechanism for negotiation on these prices because we cannot have Americans paying six or seven times what they are paying in other parts of the world.

Mr. HAISLMAIER. I think the important thing is, and Jeff and Mr. Dooley are on one side on this and I am a little different on this because I think it is important to have private catastrophic insurance, but I think the minute you have private catastrophic insurance for these Medicare beneficiaries, the first thing that those insurance companies will do is either they will use their in-house pharmacy benefit manager or, if they have not got one, they will contract with one on the outside to help keep the cost down, and to not only keep the cost down but appropriately use the medications. You do not even have to write that into the law. They will do it automatically because it is in their own interests. If they keep the cost down, they keep the premium down, if they keep the premium down, they have more market share. They will just do it themselves.

Mr. BURTON. Let me get back to some of the other questions. I do not want to belabor this point. It is nice to hear what you folks have to say and, hopefully, we will be able to resolve that. We have put out the olive branch to a number of pharmaceutical companies saying let us sit down and try to figure out some way to try and solve this problem so you do not get hurt and we also help the American consumer. And I am not sure that is something that cannot be done.

What about these out-of-pocket expenditures that will be made by individuals who have these gaps in their coverage, should that be tax deductible? Have you guys thought about that at all?

Mr. MILLER. You are saying for the gap between what the funds are in your account and above that?

Mr. BURTON. Right.

Mr. MILLER. Well, we are walking in two directions at once. We always salute the idea of having some degree of cost sensitivity by the empowered consumers feeling real market prices in order to kind of choose wisely, and then we try to bulletproof them from actually seeing what those prices are. So I guess the first answer is, if you are having a deductible or co-insurance or co-payment beyond that, why have it unless it is going to be 100 percent of the

price. Determine how much you want to subsidize on a need basis and then you should be facing the real prices in order to make the right decisions, because you are making those decisions with everything else you buy in your life, it is what it actually costs in order to allocate it properly.

Second, in terms of a tax benefit, you are going to be steering that in the other direction in which you want to be doing these subsidies. Based upon the senior population, you have a substantial number of Medicare beneficiaries who will not file any income taxes or be liable for them. So you are actually going to be doing a regressive subsidy to the higher income people by giving them a tax benefit. We have done that elsewhere in our health care system with some pernicious results. So I do not think that is the way to go. We ought to deal with the most important things first, the highest expenses, the lowest income people, and try to do less harm to kind of figuring out where prices should go apart from that.

Mr. BURTON. So you like the sliding scale that we start off with at the beginning. Once we get to that gap between the underlying coverage and the catastrophic, that should not be tax——

Mr. MILLER. Actually, I am not that crazy about sliding scales, that just kind of stretches out the distortion. The better approach is to actually figure out how to do the best job for the people who really, really need the help. See if you have any money left over. After you have already taken care of the folks with high costs and the folks at the low end of the income scale, let us see what is left on the table rather than try to spread it even wider and thinner.

Mr. BURTON. We were talking about the people who have higher income that qualify for the plan, they would get maybe $600 toward their MSA, and the people at the lower end of the scale who cannot afford it would get $2,500, and then there would only be a $500 gap between that and the catastrophic care. You say that you do not believe in that sliding scale?

Mr. MILLER. Those are political tradeoffs which may be done for political purposes. But in order to pay for that, you are preventing people who have even higher expenses from being assisted or lower incomes from being assisted in order to put the political package together. Recognize who you are not helping while you are trying to, in effect, provide additional political benefits elsewhere.

Mr. BURTON. I am not sure I follow. Did you follow what he said?

Mr. ANTOS. We will find out more later.

Mr. MILLER. Let me put it real simple. There are disabled people, there are people with long-term health care problems, there are people in horrible straits. But every dollar we take away from assisting them to give to middle class seniors means we have, in effect, redirected our charitable impulses for political reasons. So let us have folks who can afford to pay their own pay their own way, and help those who are most needy, first. And then tell me if you have any money left on the table.

Mr. BURTON. I want to tell you just one thing that you may find interesting. When I go to a town meeting and we have people there who are senior citizens, Social Security recipients, and I look in the parking lot and I do not see anything smaller than a Cadillac, I go into the meeting and they all say what are you going to do about my Social Security COLA this year. Do you see the political prob-

lem you are talking about? If you say to those people who have an income above the poverty level, and you are only going to give them $600 toward their Medicare MSA prescription drug benefit, you say we are not going to give you anything while we are giving others $2,500, and you are, in effect, means testing, that is a toughie for an awful lot of people. And to get 218 votes in the House and 51 in the Senate, maybe even 60 in the Senate, that is virtually impossible. So while you are talking pie in the sky, and I might agree with a lot of that, it ain't going to happen. You understand what I am saying there?

Mr. MILLER. Yes. I just wanted you to understand what I am saying.

Mr. BURTON. I understand now.

Mr. ANTOS. I would like to support you, Mr. Chairman, in terms of simple pragmatism. In the end, all we are really talking about is what is the net subsidy to different groups of people. And it is, I agree with you, it is often very helpful to have different mechanisms. And, frankly, complication can be our friend in Government, as we both know. Let me say there is actually a good economic reason sometimes to also, as Tom said, spread out the subsidy, and that is, economists think in terms of marginal tax rates. So a not very good situation would be if there was a gigantic subsidy, say a $5,000 subsidy, for everybody up to a certain income level, but $1 more and the subsidy was zero. You would find all sorts of unfortunate personal reactions to that to avoid being on the wrong side of the cusp. Of course, there would be people with much higher incomes who would not worry about it. But people pretty close to where you hit the cliff on the subsidy will do all sorts of things to try to conceal income, shed themselves of any proof that they may actually be slightly above. So there is good reason to avoid that problem.

Having said that, however, income may not really be the only measure to think about. As I think everybody knows, the elderly as a group have the highest average asset level of any population group. That will always be the case just because of the normal pattern of the way we live. And so if you tie it to income, you are still not quite there. This is not an argument for it making more complicated. We just have to recognize the inevitable inability to fully target the people we really want to hit.

Mr. BURTON. You all read the bill that we proposed, you had a chance to look at it. Let me just go down the line and ask, real quickly, are there parts of the bill that you think are workable and should be in a prescription drug bill, and what are they? What I would like to find out is, is there anything that all four of you and your institutions can agree upon that should be in the bill that is in it currently. Let me start with you, Mr. Haislmaier.

Mr. LEMEIUX. I will start. I have the microphone in front of me.

Mr. BURTON. Sure.

Mr. LEMEIUX. I think it would probably be hard because I do not think that our group would be interested in a discount card and catastrophic benefit that only applies to the low-income. We would like to see everybody in Medicare get at least discounts and a catastrophic benefit. So the idea of targeting this cash benefit to the poor and people with low incomes is fine, but it seems like some

sort of universal discounts availability and catastrophic would be pretty important to our group.

Mr. BURTON. What would that do to the cap that we are talking about, the $200 billion cap over 10 years?

Mr. LEMEIUX. You would have to have a higher catastrophic level than $3,000, probably by far, to fit a more universal catastrophic into a $200 billion cap.

Mr. BURTON. So you are talking about a bigger gap between the underlying coverage of $500 for a person who got $2,500 and, say, if you went to $4,000, it would make it $1,500.

Mr. LEMEIUX. Yes. You might have to go above $4,000.

Mr. BURTON. There again is another political problem. I think you would have a problem with the more liberal Members saying that the poorer people could not afford that gap. But if you did that and you did not have that gap that you are talking about, then you would have to go way above the $200 billion cap over 10 years we are talking about. Therein lies the rub.

How about you?

Mr. HAISLMAIER. As you put it forward, it is just a catastrophic and then there is really nothing below the catastrophic. So, in effect, as I understand this, you are looking at, say, $3,000. That is really both a stop-loss and a deductible in one, if I understand this correctly.

Mr. BURTON. Well, it is, in effect, a deductible. But they get the MSA money——

Mr. HAISLMAIER. Right. And I absolutely agree with that. But my point is that, in terms of the benefit design, it is both a stop-loss and a deductible. In other words, below $3,000, the beneficiary pays, albeit with some help from the funds you are providing depending on their income, and above that the beneficiary basically does not pay, if I understand this. It is a no co-insurance. So one way to adjust that is to actually separate the deductible and the stop-loss which allows you to move from $3,000 in opposite directions. And you benefit here from the fact that they have made such a mess of the existing bills with the donut hole that your reference point is now not the perfect or the ideal but what is in H.R. 1 and S. 1.

If you were to do this. If you were to say $1,000 deductible, and a $6,000 stop-loss, and 50 percent co-insurance in between, 50–50, and that is the standard, and we will leave aside the question of whether the Government does it or the private plans——

Mr. BURTON. What do you do about the $6,000 stop-loss?

Mr. HAISLMAIER. That is what I am saying. It is 100 percent. The beneficiary pays nothing above $6,000 in total drug spending. And by the way, I agree with Jeff that the right way to do this is to say that it is based on total drug spending. And I also agree with Jeff that you want catastrophic for everybody. That is not only an equity issue but I think it makes good health policy. So above $6,000 in drug spending, the beneficiary would pay nothing. The first $1,000, the beneficiary would pay 100 percent. Between $1,000 and $6,000, the beneficiary would pay 50 cents on the dollar. OK? Let us just use that as an example. If you did that, that would have total cost-sharing of $3,500, which is what is in the House bill, better than what is in the Senate bill, less cost-sharing than

what is in the Senate bill, but you have gotten rid of the donut hole because you have put a front end deductible on it, and at the same time you have raised the catastrophic.

Mr. BURTON. But for the indigent and the poor that we have——

Mr. HAISLMAIER. Well, so what you have is you are saying their maximum cost-sharing is $3,500, what are we going to put toward that. Are we going to give them $2,500? Are we going to give them $1,500? $1,000? Then you decide how much you are going to put toward that in your MSA debit card kind of arrangement.

Mr. BURTON. So you are talking about an adjustment in the bill saying, OK, we would, for instance, the sliding scale, which some of you do not like, $600 up to $2,500, and then between that and some figure that would be actuarially sound we would go to a 50 percent match.

Mr. HAISLMAIER. You could do something like that. And then for the employers, you could say, look, if you are an employer plan, you need——

Mr. BURTON. I understand. But what do you do with the indigent who gets the $2,500, for instance, as a base and you go up to, say, 50 match to $6,000, that means they would have to pay half of the $3,500, what do you do with them if they cannot afford that?

Mr. HAISLMAIER. That is what I am saying. You really have to sit down and figure out where you want your budget number to come out. But it is one of two things. Either you adjust the benefit for everybody, in other words, instead of saying it is $1,000 and the stop-loss is at $6,000, we will say the stop-loss is at $5,000, or something, but you can either adjust the benefit, which impacts everybody, or you adjust the contribution, which impacts only those people that need it. So you can say for these lowest of low-income people, instead of $2,500, we will give them $3,000.

Mr. BURTON. Have you drafted anything like that as a proposed model?

Mr. HAISLMAIER. Yes. I have a set of specs I can share with you, Mr. Chairman.

Mr. BURTON. Would you send those to us because I would like to see those.

Mr. HAISLMAIER. I will send it to the staff.

[The information referred to follows:]

Alternative Medicare Drug Coverage Proposal

Description and Rationale

The proposal outlined below would provide for private plans to deliver catastrophic prescription drug coverage and then provide income related subsidies that could be used to pay the premiums and cost sharing for those plans, as well as for employer-sponsored retiree coverage plans, or Medicare Advantage plans (which would have integrated drug coverage). Under this approach:

- The subsidies would be delivered through a debit card, issued by the plans. Every plan would have a natural incentive to minimize drug expenditures in order to minimize the number of beneficiaries who reach the deductible or the stop-loss. Consequently, all of the participating stand-alone, employer or Medicare Advantage plans would contract with PBMs to administer the drug benefit portion of their coverage. The PBMs would then combine the claims processing and discount access features that they currently offer with the new debit card. There would be no need for any additional regulation or certification of the PBMs as long as there were basic information disclosure and patient privacy requirements on the qualified plans (and most, if not all, of that is already in statute and can simply be incorporated by reference.)

- A qualified plan would be any plan that meets current insurance regulations (either state law, or ERISA if an employer or union sponsored plan) and meets the statutory minimum coverage design.

- The statutory minimum coverage design would consist of a substantial deductible with further cost sharing, but without any coverage gap and with a true stop-loss. Any actuarially equivalent benefit design would be permitted.

- If desired for political reasons, the legislation could be written to make the total out-of-pocket costs to the beneficiaries under the minimum coverage design the same as they are under either HR 1 or S 1. For example, HR 1 limits total cost sharing to $3,500. The same result can be achieved with a $1,000 deductible and 50% cost sharing up to a stop-loss level of $6,000 in drug spending. Alternatively, the deductible could be, say, $1,500 with 50% cost sharing up to a stop-loss level of $5,500, with again, the same result.

- The debit card with the income related subsidy could only be issued through a qualified plan, thus giving beneficiaries a strong incentive to obtain coverage and minimizing the coverage vs. no coverage selection effect.

- National or regional stand-alone drug plans could be created. They could charge whatever premium they felt appropriate. When the beneficiary signed up for a stand-alone drug plan the plan would issue the debit/discount card to the

beneficiary with the annual premium pre-debited. Also, publishing the loss-ratios of stand-alone plans would both allow for appropriate consumer comparisons and avoid the need for premium negotiations or government review of premiums.

It would be much easier for employer plans to conform to the "qualified coverage" standard, and their retirees could use their subsidy to pay any premiums and cost sharing under such plans. The net effect would be to provide some indirect subsidy to current employer-plans, but otherwise not disrupt those existing arrangements. (If enacted, it can be presumed that employers will adjust the premiums and cost-sharing they charge their retirees in their plans to capture much of the new subsidy their enrollees would receive from Medicare.)

Concerns about low-income beneficiaries could be addressed by varying the government's contributions to their debit cards.

Assuming it is politically necessary to have a "fallback" plan, the fallback plan would be a debit card issued by a PBM without any insurance component. For beneficiaries in this situation, more money could be added to their debit cards to compensate for the lack of insurance coverage.

A private, self-funded reinsurance pool would be set up and run by the participating plans to deal with any selection effects among plans. This would essentially be a back-end risk adjustor. This would also mitigate the danger of plans shifting risks to the government as would occur under either H.R. 1 or S. 1 or alternatives such as the Dooley bill. But like the Dooley bill, it would also encourage employers to continue offering coverage as they could get some relief for catastrophic expenses.

The degree of government aggregate expenditure control would be a function of the formulas for determining how much money is contributed to each beneficiary's debit card. The strictest control would be annual appropriations distributed to beneficiaries according to a formula. In that scenario, if the number of beneficiaries increased, the per-beneficiary contribution would need to be scaled back, and there would be no increase to account for changes in price, volume or mix of drugs consumed. A partial entitlement approach would fix the annual contribution rates but allow total expenditures to grow with enrollment growth. A full entitlement approach would not only have expenditures grow to keep pace with enrollment growth, but also index the government contribution amounts by some adjustor that reflected, in whole or in part, changes in drug price volume and mix (e.g., using a CPI adjustor would only compensate for some of the growth. In contrast, using a "drug expenditure growth" index would be very inflationary. This is because only 2-3 percentage points of the 15-18 percentage annual growth in drug expenditures is actual price inflation. The rest is increased volume and changes in the mix of drugs consumed.).

Proposal Specifications

Section A - Debit Card:

1) All Medicare beneficiaries are given an outpatient prescription drug debit card.

2) An amount is annually contributed to the debit card by Medicare.

3) The annual amounts contributed to the card should be income related. (The different amounts for beneficiaries in different income categories needs to be specified in the legislation along with any adjustor for future years).

4) The card may only be issued by, and used in conjunction with, a "qualified retiree outpatient prescription drug plan."

5) Funds can only be used to pay: 1) the premiums for a "qualified retiree outpatient prescription drug plan;" 2) the premiums for a Medicare Advantage plan (all of which would include drug coverage at least equal to that in a stand alone drug plan), or; 3) out-of-pocket expenses associated with either type of plan.

6) Unused amounts may be;

   a) Rolled over from year to year as long as the beneficiary is enrolled in a "qualified retiree outpatient prescription drug plan" or a Medicare Advantage plan.

   b) Transferred to the card of the beneficiary's spouse, if the spouse is a Medicare beneficiary enrolled in a "qualified retiree outpatient prescription drug plan" or a Medicare Advantage plan.

   c) Transferred to the card of a surviving spouse if the surviving spouse is a Medicare beneficiary enrolled in a "qualified retiree outpatient prescription drug plan" or a Medicare Advantage plan.

Section B - Plan Requirements:

1) To be a "qualified retiree outpatient prescription drug plan," a plan must:

   a) Be a state approved and regulated commercial insurance plan, or an employer-sponsored retiree plan (ERISA plan), or a Medicare Advantage plan.

   b) Have a beneficiary out-of-pocket stop-loss set at a level of total drug spending (not beneficiary out-of-pocket spending as in the current bills) that doesn't exceed an amount specified in the legislation. (The stop-loss should probably be

set in the $5,000 to $10,000 of total drug spending range. Also, the stop-loss level should be indexed for future years.)

c) Have a deductible that doesn't exceed an amount specified in the legislation. (The deductible should probably be set in the $1,000 to $1,500 range. Also, the deductible should be indexed for future years.)

d) Have a beneficiary cost-sharing between the deductible and the stop-loss level that doesn't exceed an amount specified in the legislation. (A maximum beneficiary cost sharing level of 50% would be consistent with both bills).

e) Alternatively, have a plan design that has the same stop loss level as b) above and is otherwise actuarially equivalent to c) and d) above. (This should be a broad actuarial equivalence provision -- not narrow actuarial equivalence that effectively turns "equivalent" into "identical" as the current bills do. The idea is to let plans substitute tiered copay arrangements for the deductible and coinsurance if they want to.)

f) Comply with the patient information/disclosure (e.g., disclosure of premiums, cost sharing structure, formulary restrictions and coverage determination appeals processes) and confidentiality of medical records provisions of this act.

g) Meet the conditions specified in Section (B)(2) or (B)(3) or (B)(4), depending on the type of plan.

h) Participate in the reinsurance program in Section C.

2) If the plan is a commercial plan, the plan must:

a) The plan must meet the coverage requirements in Section (B)(1)(b), (c) and (d) or (e) above.

b) Be approved by the applicable state insurance regulatory authority in each state in which it is offered.

c) May not limit coverage to a geographic area smaller than an entire state.

d) Be certified by CMC to participate in the program. Upon presentation to CMC of approval by the applicable state regulator(s), and a review by CMC to determine that the plan meets the requirements of this act, CMC shall certify that the plan may participate in the program.

e) Publish the plan's previous year loss ratio in the plan's consumer information and in any comparative consumer information distributed by CMC. Plans would be permitted to pay enrollees end-of-year refunds to achieve better loss-ratios.

f) Be guaranteed renewable.

g) Charge the same premium to all enrollees (the standard rate), except as provided for in Section (B)(2)(h).

h) Be guaranteed issue at the standard rate:

i) To all Medicare beneficiaries during the initial open season.

ii) To newly eligible Medicare beneficiaries during a 90-day enrollment period following the date they first become Medicare eligible.

iii) To all Medicare beneficiaries with creditable coverage during subsequent annual open seasons.

i) For all open seasons following the initial open season, the plan must charge applicants who cannot show evidence of creditable coverage, and are not within the 90-day enrollment period for new Medicare beneficiaries, 200% of the standard premium for the 12-month period following enrollment in the plan.

j) "Creditable coverage" is defined as coverage for a period of at least 12 consecutive months, with no gap in coverage, under any commercial, employer-sponsored or Medicare Advantage plan certified by CMC to participate in this program.

k) A CMC certified plan may be offered as a rider to a Medicare Supplement plan. (Should also consider adding the minimum drug coverage to all Medigap standard plans, with instructions to NAIC to design a revisions to Plans H, I and J to rationalize their current, front-end drug coverage with the new catastrophic coverage design).

3) If the plan is an employer-sponsored retiree plan:

a) The plan must first be approved by CMC before the plan can participate in the program.

b) To be approved by CMC the plan must:

i) Meet the coverage requirements in Section (B)(1)(b), (c) and (d) or (e) above.

ii) Be in compliance with all applicable provisions of ERISA.

iii) Not exclude from coverage any individual eligible for retiree health benefits provided by the sponsor and who is also a Medicare eligible

individual.

iv) Not vary the premium or benefits for any eligible individual on the basis of the individual's age, sex or health status.

v) Participate in the reinsurance mechanism in Section C.

4) If the plan is a MedicareAdvantage plan:

a) The plan must meet the coverage requirements in Section (B)(1)(b), (c) and (d) or (e) above.

b) Otherwise meet all the requirements for a MedicareAdvantage plan.

c) The full amount of a beneficiary's debit card may be applied toward paying the beneficiary's share of premium for the MedicareAdvantage plan.

Section C - Reinsurance mechanism:

1) A reinsurance pool is established as an independent, government-sponsored, non-profit, self-governing entity.

2) All qualified retiree outpatient prescription drug plans shall be members of the pool.

3) The pool shall be governed by its member plans, with each participating member plan having voting rights apportioned according to its respective share of the total number of covered lives covered by "qualified retiree outpatient prescription drug plans" issued or sponsored by all of the member plans participating in the pool.

4) Member plans may cede to the pool the 90% of the excess claims for any covered individual who has meet the stop-loss level, specified in Section (B)(1)(b), for the year.

5) Member plans shall be annually assessed, on a per-covered life basis, a proportionate share of the total claims paid by the pool.

6) Each year the pool shall estimate its losses for the year, determine the annual assessments for the various plans, and notify each plan of the amount of its assessment for the coming year, sufficiently in advance of the annual open season for commercial qualified retiree outpatient prescription drug plans and MedicareAdvantage plans as to enable the plans to build the assessments into their rates for the coming year.

7) Assessments shall be billed and paid on a schedule determined by the pool (e.g., annually, quarterly, or monthly).

8) The pool shall have authority to borrow money to cover any shortfall until the next assessment.

9) Any surplus shall be held by the pool to pay future claims and at the end of each year shall be applied in calculating the assessment for the next year.

10) An amount of $TK is appropriated for FY 2004 (or the year prior to that in which the program starts) to fund the initial costs of setting up the pool.

Section D - Responsibilities of the Center For Medicare Choices (CMC)

1) Certify all plans.

2) Administer the initial and subsequent annual open seasons for commercial "qualified retiree outpatient prescription drug plans."

3) For any year in which a one or more states do not have at least one commercial "qualified retiree outpatient prescription drug plan" available to Medicare beneficiaries residing in the state, CMC shall enter into a contract with a pharmacy benefit manager to issue and administer debit/discount cards to eligible beneficiaries in one or more of the affected states. (i.e., could be one or more PBMs but not more than one PBM per affected state). Neither Medicare nor the contract PBM would provide the drug insurance benefit specified in Section B. (Might want to consider adding more money to the debit cards for beneficiaries in this situation, since they wouldn't have access to drug insurance coverage.)

Section E – Other Provisions:

1) Definition of covered drugs (same as in current House and Senate bills).

2) Specify times of initial and annual open seasons.

3) Patient information/disclosure and confidentiality of medical records provisions.

For more information contact: Ed Haislmaier (202) 408-0620

Mr. BURTON. That is what I am trying to get out of you guys today. Not that you are going to agree with me 100 percent, which you should, which I am sure you are not, but I would like to get your ideas so we can try to incorporate them into a final bill draft that has as broad support as possible. I know we are not going to get everybody. But that bill that is in conference probably is not going to get everybody either. It may not even pass.

Mr. HAISLMAIER. My point is simply that the bill in conference does actually work to your advantage because you now have that as the comparison. So if you can say well, look, for the same cost-sharing, I get rid of the donut hole and this looks more like real insurance, then, yes, it has higher deductibles but we are going to give people money up front to help pay for it, you may have a case there.

Mr. BURTON. If you have a model like that, I would like to see those specs.

How about you, Mr. Lemeiux?

Mr. LEMEIUX. Just let me add to that. It is still not going to solve your cost problem. The cost problem is just going to be intense. And what I was wondering is, to try and compete with H.R. 1 or S. 1 in terms of we are going to give you more for your money, it might be very difficult because they have already gone to such enormous contortions to try and get that thing so that it looks OK within the $400 billion budget. What they have done, of course, is made it so that it does not work and it is politically probably impossible to pass.

But what I was suggesting is maybe it is time to just sort of say, look, if our budget is only $200,000, or $300,000, or $400,000, or wherever it ends up, that we just have to be up front and say we cannot afford something that looks like a drug benefit. Therefore, all your guys over there are going to get is catastrophic and discount, and then we're going to set aside a big chunk of money to help the poor as best we can, and it still might not be sufficient. You know, people will say, "It's just not enough for the poor." And that could be just a negotiable item, to try to do as well as we can.

But I still think that even if you work with the Dooley bill, if you work with that Haislmaier plan, you're still going to run up against this cost constraint, and at some point, trying to compete with H.R. 1 and S. 1 on the desirability of the benefit package is just going to be hard.

Mr. BURTON. Well, the one thing we have to do is we have to be as realistic as possible and not be "pie in the sky," and that's why I'm asking for your recommendations.

Mr. BURTON. Mr. Miller.

Mr. MILLER. Compromise is usually not the first criteria or priority at the CATO Institute. [Laughter.]

Mr. BURTON. I understand. I understand.

Mr. MILLER. Just common sense proposals for the average American.

Mr. BURTON. That sounds like a good political theme, compassionate—[laughter.]

Mr. MILLER. But let me kind of suggest a couple of kind of markers in this regard. If you are going to count other spending as qualifying for the out-of-pocket costs beyond real out-of-pocket

costs, then let us make sure that they are close to out-of-pocket as opposed to kind of the amount you spend under employer coverage or a Medi-gap coverage or some other type of third party coverage. Do not count all those dollars, just count how much you paid for that spending, in other words, the premiums you spent rather than what it might have covered, because there is a mismatch between those two. So let us get equivalence in what people are spending at some point out of their own pocket if we are going to use that to trigger what the deductible or the stop-loss levels are equivalently.

Second, I think that most of these bills, yours is at 250 percent of poverty, Congressman Dooley's bill is at 200 percent of poverty, we need to look at the numbers here and say we are not targeting, we are actually spreading this pretty broad. Two hundred percent of poverty, by the last set of numbers I saw, is 55 percent of all Medicare beneficiaries. That does not sound like targeting to me. I would say we ought to get down to about 150 percent of poverty and see what we have left at that point where we are actually targeting on the basis of income.

In addition, I concur in general terms, the problem is always with the details, with Ed and Jeff on the need for catastrophic coverage. That is the most important type of insurance to have, although a lot of people do not want catastrophic coverage, they want first dollar coverage, they want something they can have. But if you are going to have catastrophic coverage, you have to have more than one source of the negotiated prices. You have to have a number of bidders out there, finding out how they mix and match the prices, the particular drugs, the way we should deliver it, you are trading off prices for one and the other. So that is why we want to have multiple private players determining what that catastrophic coverage is and what it costs. If you then want to subsidize the premiums for that catastrophic coverage once you know what it actually costs in a real market, then determine how you want to subsidize the premiums for it. But do not forestall the process of figuring out what that catastrophic cost actually requires and how different people go about delivering it.

Finally, just to focus, and I agree on kind of the general concepts in terms of the sickest and the poorest, we need to determine who we are going to subsidize first, how much we are going to subsidize them, and what is the sustainable criteria by which we determine that. If we do not have that anchored in place, then it is just going to be which ever way the winds blow from year to year.

Mr. BURTON. Do you have on paper proposed legislation that would do what you are talking about?

Mr. MILLER. I am always concerned that any legislation I would propose would be adopted must be a mistake on my part. [Laughter.]

I immediately rethink it. However, we are forthcoming with a lengthy overview of the Medicare legislation.

Mr. BURTON. As a possible adjunct to something we are working on, I would like to have your thoughts in writing, if I could get those. That is really something, any legislation that you would propose would be wrong because it was passed into law and you made a mistake, right?

Mr. MILLER. It is worth a second thought.

Mr. BURTON. It is worth a second thought. OK.

Go ahead, Mr. Antos. And then I have one more question I want to ask and then I will let you guys go.

Mr. ANTOS. I feel Tom's pain. Rather than repeat some of the things that people have said, I would urge you to hold to the idea of a $200 billion bill. Just do not imagine that you can do it the easy way by saying it will be $200 billion. That just does not work. Design the bill so that it will be $200 billion. Now, of course, we have a bit of a problem. As you know, I used to work at the Congressional Budget Office and one man's $200 billion is another man's $600 billion, so we could get into theological debates about that. But in truth, it is the design of the program that really should drive this.

Mr. BURTON. As a former member of CBO, maybe you could give us your thoughts in writing as well that would keep us within those cost confines.

Mr. ANTOS. I will do the best I can.

Mr. BURTON. I would like to have it.

The last thing I want to ask you, and we have addressed this a little bit, how do you keep the private sector, assuming that the plans you are talking about were adopted or enacted into law, how do you keep the private sector in the game by keeping their plans instead of junking them and trying to throw them on the Government?

Mr. HAISLMAIER. Basically, what I would propose is if you have private sector catastrophic insurance that any of those employer provided plans would automatically qualify provided they met the catastrophic cap, whatever that was.

Mr. BURTON. What about some of them have first dollar coverage, some——

Mr. HAISLMAIER. Well that is fine. They could offer more. There is nothing wrong with them offering more. It is saying here is the minimum. In other words, what you are doing is you are putting a minimum standard.

Mr. BURTON. What I am saying, though, is if they have first dollar coverage and they have the other things you are talking about, what is to keep them from dumping a large part of the coverage and saying, OK, we will only do the minimum that we have to do in order to qualify?

Mr. HAISLMAIER. There is an economic and there is a quasi political. The economic is, as part of what I am proposing, is that everybody would be able to reinsure their catastrophic. So that would help to keep them in the game. The political is, the reality is that a lot of these employers want to dump it but they are trying to use you as an excuse and blame you, the Congress. So if you take yourself out of the game and you say that all we are going to do is say that your plan, if you have one, has to have catastrophic, then you have backed off the game and they are back to square one, which is saying, oh, if I am going dump them I am going to have to do it myself and I am not going to be able to blame Congress for it. So that sort of quasi political thing is what is keeping them from dumping right now and would still have some effect.

Will they scale back? Yes, there will be some scale back. But as they point out, they are doing it already. For them it is a question of how hard or easy do you make it for them. This makes it harder for them to do it. The current H.R. 1 and S. 1 make it a lot easier for them to do it because they say, oh, well, Medicare has a new benefit, we will just wrap around it.

Mr. BURTON. Well, include that in the things you give to us, if you would please.

Mr. LEMEIUX. Just to add to that. The Senate and House passed bills set up a benefit design that gives employers every incentive to drop coverage. But then they say if you do not drop coverage, we are going to give you this little extra subsidy. And so the employer has to say, well, will that subsidy still be there a few years down the road, or am I just going to go with this big incentive to drop. And what Mr. Dooley's bill would do is say, look, if you qualify, if you sign up and the Medicare program approves of the way you are providing drug benefits, then if you have someone on your rolls that hits the catastrophic limit the Government will start to help pay for that. And that gives them an incentive to actually stay in the game because the Medicare program would help them pay for their highest cost cases. So it is just the opposite, where the benefit design gives them an incentive to stay in rather than to get out. And then you do not have to provide subsidies and whatnot to try and persuade them to stay in the game. So it is a design issue.

Mr. BURTON. OK. Mr. Miller.

Mr. MILLER. The short answer always is if you want to keep the private sector in, keep the Government out. But beyond that, we are seeing in terms of the private sector coverage that they are increasingly hitting their caps and they are going to, in effect, more of a front-end loaded type insurance, particularly in the employer plans. If you look out about 10 to 15 years, the trends are going to magnify and private employers are going to increasingly be organizing insurance arrangements for their employees but subsidized at very little, if at all. So in that sense, I think wrapping this around a type of broader catastrophic coverage will allow the private players who wish to remain in the field to probably be about where they are in any case, and that is about what we are going to be able to do.

But in the longer term, we want to be able to have individuals carrying their lifetime compensation and lifetime savings and not being forced to fit their spending decisions to the particular silos we have constructed for them where they cannot move between one and the other. And in that regard, we need to kind of step on a broader playing field of kind of providing tax advantages for saving for your entire life cycle of needs and responsibilities.

Mr. BURTON. Yes. Yes. But you are saying that you think in 10 or 15 years the employers are going to be out of funding and turning it all over to their individuals?

Mr. MILLER. They will not be out of an essential role, which is that you do not want to have isolated beneficiaries having to find something, an individual market without any choices. It is very important to kind of give you good buying options. But if you look at what is being done with the younger employees, the subsidies are

being rolled back. Ultimately, you are going to pay for your coverage but you can get smarter, better coverage through an enlightened employer. And that is an important role for employers to continue to perform in the future.

Mr. BURTON. OK. Mr. Antos.

Mr. ANTOS. I guess I would concur with Tom's remarks, in particular. No matter what we do, short of paying 100 percent of the cost, we will not be able to keep some employers in the game. It is just impossible. The question really is, is anything Congress enacts this year or next year going to accelerate the dropping of employer-sponsored coverage. I think that is the issue. So I think most of the numbers that people have been talking about have confused sort of the total change and the acceleration due to the bills.

I agree with having catastrophic coverage that runs through the Government but is operated through private plans and where the individual is invested with, in essence, his own subsidy. I think that strikes me as the most sensible way to go from all perspectives. First of all, the individual's hands are no longer tied. Second of all, the individual has ownership of the resources, something that no Medicare beneficiary has today. I think that is more important as an objective than trying to hold back the tide. The tide is going out.

Mr. BURTON. The tide is going out. So you would put a little more competition in the whole system if they had control of their own resources, as much as possible.

Mr. ANTOS. I think that is critical.

Mr. BURTON. Well if I could get all of you to give us these vast ideas we have talked about in writing, we will try to retool our proposal and see if we can incorporate some of your ideas.

I appreciate very much your taking the time to come and talk with us today. Thanks an awful lot.

We stand adjourned.

[Whereupon, at 2:10 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[Additional information submitted for the hearing record follows:]

October 13, 2003

The Honorable Dan Burton
United States House of Representatives
2185 Rayburn House Office Building
Washington, D.C. 20515-1405

Dear Chairman Burton:

Thank you for the opportunity to testify before the House Committee on Government Reform's Subcommittee on Human Rights and Welfare regarding a targeted Medicare prescription drug benefit for low-income seniors. If the Congress is unable to reach agreement on a broader Medicare proposal, a low-income benefit could provide important financial assistance to many seniors and disabled people facing high prescription drugs costs.

Your proposal, the Medicare Safety Net Prescription Drug Act, would focus government subsidies on people with incomes up to 250 percent of poverty, but only if they were not eligible for other prescription drug coverage. If they were implemented successfully, those provisions would minimize the substitution of taxpayer dollars for money that is already being spent by individuals, private insurers, and state governments for the prescription drug needs of Medicare beneficiaries. Moreover, your proposal recognizes the problems of first-dollar insurance, which reduces the cost consciousness of beneficiaries. By providing much of the subsidy in the form of a personal drug account, the proposal encourages beneficiaries to spend those resources wisely.

I believe that the proposal should be modified in significant ways to assure a proper balance between limiting government cost and providing beneficiary access to a continually improving pipeline of effective new drugs. My statement before the committee addresses many of my concerns regarding the role of regulation and price setting in a Medicare drug benefit. I elaborate on several specific points in what follows.

Consumer Preferences. The Medicare Safety Net Prescription Drug Act (referred to as the Safety Net Rx proposal below) gives every eligible beneficiary the same prescription drug benefit regardless of circumstance. But seniors often have differing opinions about what is best for themselves. Allowing a choice of benefit structures administered by competing health plans would allow seniors to select the plan that best meets their needs. Some might prefer a heavily managed plan that requires little out-of-pocket spending while others might be willing to spend more for a less managed plan. This is precisely the type of choice offered in the Federal Employees Health Benefits Program.

The Safety Net Rx proposal has a "doughnut hole" in the drug benefit that is similar to that of H.R. 1 and S. 1. The proposal assumes that beneficiaries would spend their entire government subsidy, and then face gaps in coverage until the stop-loss spending level was reached. Many beneficiaries would prefer continuous coverage without such a hole in the benefit. That can be achieved by plans managing costs through multi-tiered copayments and other techniques that encourage prudent purchasing on the part of consumers.

Instead of a single government-defined benefit, the proposal should encourage private plans (including comprehensive health plans and stand-alone drug plans) to participate in the program. Beneficiaries would select the plans that offer what they consider to be the best value, rather than merely the lowest price.

Private Plan Participation. Three steps could be taken to ensure that private plans participate in the Medicare drug benefit. First, the program should be open to all types of health plans with minimal regulatory burden. Employer retiree plans, private insurers, integrated health plans, and others would be attracted to such a program, but only if they could essentially operate as they do now. Some minimal requirements to assure consumer protection would, of course, be necessary. However, plans should be allowed wide latitude to determine their benefit structures, cost-sharing requirements, premiums, and other aspects of their individual offerings.

Second, plans should be placed at financial risk for the catastrophic insurance benefit and a national reinsurance pool should be established to make that risk manageable. Such a pool would spread excess costs among all beneficiaries, eliminating the incentive to avoid enrolling sicker seniors. Premiums would include the cost of those high expenses averaged over all Medicare beneficiaries. That would protect private plans from the problems of adverse selection and provide greater incentive for plans to participate in the program. All Medicare drug plans would be members of the pool. Although the government would facilitate its creation, the reinsurance pool would be fully self-funded and managed by its members.

Third, risk bearing for private drug plans should be phased in over several years. Insurers and health plans need detailed data on spending patterns of beneficiaries. That information can only be developed with actual experience offering a Medicare drug benefit. After a year or two, however, plans should be able to predict the cost of the benefit and determine fairly accurately how seniors react to aspects of the benefit design.

Federal Cost. Many features of the Safety Net Rx proposal are intended to limit federal cost, but some of those provisions would be ineffective or have unacceptable consequences. My recent testimony addressed the problems of federal price setting, drug importation, and capping outlays as envisioned in the proposal. Other concerns include the zero premium provision, eligibility restrictions, and limits on the individual accounts.

Zero Premium. Under a competitive proposal, plans would be able to set their premiums and benefit structures to attract enrollment. The Safety Net Rx proposal does not give beneficiaries a choice of plans but does not charge a premium for the one plan that would be made available. One reason for that is to assure full participation, although other eligibility restrictions clearly intend to reduce participation. Nonetheless, a zero premium for a new benefit is a poor precedent that fosters the incorrect notion that Medicare beneficiaries have already "paid" for their drug coverage. A token premium (say, $5 or $10 per month) or even an annual membership fee (say, $25) is desirable even though it will generate very little revenue.

Eligibility. Restricting eligibility to low-income people who are not eligible for other drug coverage would be difficult to enforce, and might induce some new enrollment in the Medicaid dual eligible program. The only way to be certain that someone is not eligible for Medicaid is to put that person through the intrusive Medicaid eligibility determination process, which would impose a heavy new burden on the states and increase program costs to the extent that new eligible people are found. Excluding people who are actually enrolled in some drug plan may be somewhat easier to enforce, although even that requirement is problematic. These restrictions are needed under the current proposal because of the very generous subsidies that would be offered. Alternatively, reducing the subsidy amounts and opening the program to private plans would be a more effective way to manage federal cost.

Individual Accounts. The Safety Net Rx proposal limits the use of individual accounts in ways that reduce their value in encouraging prudent purchasing by consumers. The account would not be a permanent asset for the beneficiary, and any cash balance reverts to the Treasury if the beneficiary loses eligibility or dies. Under those circumstances, beneficiaries would have an incentive to spend from the account if they felt that the account balance could be taken away at any time.

The proposal does not permit beneficiaries or others to contribute to the account. Personal contributions should be encouraged as a way of building up an individual's financial reserves against severe illness, but that would only be possible if seniors' contributions permanently remained under their control.

The proposal also limits the use of the accumulated funds to prescription drugs. While that may seem sensible at first, eventually individuals will develop very large balances that could be appropriately used for other essential health expenses (including payment of the Medicare premium).

New Bureaucracy. It is unnecessary to create a new administrative division within the Department of Health and Human Services as the Safety Net Rx proposal is written. The proposal expands traditional Medicare's pricing and control procedures to prescription drugs, rather than creating new expectations for the program. Under those circumstances,

it is wasteful to create another bureaucratic structure. If a competitive approach was proposed, a new agency or division might well be justified.

Conclusion. A Medicare prescription drug benefit enacted this year will establish a framework for the cost and management of the overall Medicare program for many years to come. We should avoid the mistakes of past reforms by building flexibility into the legislation and allowing consumers the opportunity to select the health plan that is right for them. Apart from a Medicare bill, Congress should encourage the Administration to aggressively pursue actions to assure that pharmaceuticals are traded fairly on the international market.

Thank you, Mr. Chairman, for this opportunity to more thoroughly discuss my concerns on a Medicare prescription drug benefit. I welcome the opportunity to further assist the Committee in its important work

Sincerely,

Joseph R. Antos
Wilson H. Taylor Scholar in Health Policy
and Retirement Policy

cc: The Honorable Diane Watson
Ranking Minority Member

U.S. Senator Chuck Hagel

Testimony before the House Committee on Government Reform
Human Rights and Wellness Subcommittee

"A Medicare Prescription Drug Safety Net: Creating a Targeted Benefit for Low-Income Seniors"

Wednesday, September 24th, 2003 at 12 P.M.

Thank you, Mr. Chairman, for asking me to testify before the House Government Reform Committee today.

Medicare is one of the two largest programs in the federal government. Today, Medicare covers over 40 million Americans, including 35 million over the age of 65 and nearly 6 million younger adults with permanent disabilities. Medicare serves all eligible beneficiaries without regard to income or medical history.

It is projected to pay out $269 billion in both Part A and Part B benefits this year. This accounts for 13% of the federal budget and one out of every five dollars spent in America on healthcare.

In 1965, when Medicare was created, only about half of America's seniors had health insurance, and fewer than 25 percent had adequate hospitalization insurance. Now, because of Medicare, nearly all seniors have coverage.

Medicare has been good for seniors, and has become a dominant part of the U.S. healthcare system. But Medicare does more for seniors than protect their health. Medicare improves their quality of life. Since Medicare was enacted, people are living longer, and living better.

Life in America has changed dramatically over the last 40 years, particularly healthcare. Medicine today addresses all conditions and diseases, with a special emphasis on preventive medicine and management of chronic conditions. This includes prescription drugs, diet, exercise and lifestyle - health dynamics that were not given much consideration when Medicare was enacted in 1965.

Medical technology has exploded, and we have experienced a revolution in the development of new and effective pharmaceuticals. Outpatient treatment and prescription drugs have become mainstays of medical care.

But Medicare is a 1960's model trying to operate in a 21st century world. It does not reflect these changes in healthcare. Like medicine itself, the Medicare program must adjust and reform to address these new realities in healthcare, delivery, consumer demand, and costs.

Our goal in Congress should be to bring this valuable program in line with today's healthcare needs in a responsible and sustainable manner, and prepare Medicare for the future.

For example, Medicare does not currently cover outpatient prescription drugs. Since 1999, drug prices have risen about 20%. The average cost of these life-saving pharmaceuticals will likely continue to increase, placing further pressure on seniors with fixed incomes. More than one quarter of Medicare beneficiaries have no prescription drug coverage. Adding a responsible, sustainable, and meaningful drug benefit is a top priority for most of us in Congress.

We must recognize, however, that in doing so, we are greatly expanding America's largest health entitlement program. In making decisions, we must not discount or minimize what we know has worked, and what has not worked. A Medicare drug benefit must deal with the realities that people are living longer and better, and have higher health care expectations than ever before. A new drug benefit should pay particular attention to those in greatest need who have no options today, while not excluding other seniors.

We must also take care that we do not inadvertently stifle innovation in the private pharmaceutical, medical research, and healthcare sectors. We know advances in research and medicine have been critical factors in our increased lifespans, better health, and improved quality of life. Public-private relationships in these areas have been essential to that success. The United States leads the world in medical innovation. Our actions must not jeopardize that continued innovation, but rather strengthen it for the future.

Tough choices and difficult decisions will have to be made. Most seniors could use some help, but we have limited resources, and thus we need to target benefits to those who need it most: those with low incomes, and those with very high drug expenditures.

That is why I am participating in this hearing today. My colleagues Senators Ensign, Lugar and Inhofe and I have again introduced legislation that would give seniors assistance with drug expenses, as well as security and protection from unlimited out-of-pocket prescription drug costs.

Our bill, S. 778, the Medicare Prescription Drug Discount and Security Act of 2003, would provide America's seniors peace-of-mind regarding escalating drug expenses. The program would be available to every beneficiary in need of coverage, and would provide access to price discounts on prescription drugs and protection from unlimited out-of-pocket costs.

The benefit would have no premiums, deductibles, or gaps in coverage, and would target help to seniors with low incomes and high drug expenditures. The simple, easy to understand benefit would also be affordable to seniors and taxpayers.

All non-Medicaid eligible Medicare beneficiaries would have the option of enrolling in a discount drug card program that would give them access to privately negotiated discounts on prescription drugs.

Seniors enrolled in the program would also be protected from unlimited out-of-pocket prescription drug expenses. No longer will seniors have to pay retail for their prescription drugs or defray catastrophic drug costs by having to mortgage their home, declare bankruptcy, or spend down their life savings in order to qualify for Medicaid.

The plan has two components:

1. Discount drug card: Medicare beneficiaries could choose to enroll in a drug card program, giving them access to privately negotiated discounts on prescription drugs. These plans would provide seniors with drug prices matched to the lowest negotiated price the plan receives for the drug.

Seniors would pay no premiums. Beneficiaries wishing to participate in the plan would pay a modest annual enrollment fee of $25, which would be waived for those below 200% of poverty.

2. Catastrophic Coverage: All participating beneficiaries would be protected from unlimited out-of-pocket drug expenses through a cap on their private expenditures. The annual out-of-pocket limit for low income seniors would be $1500. Higher income seniors have a graduated out-of-pocket limit based on income, targeting help to those who need it most:

Income Levels:	Limit on Out-of-Pocket Expenses:
Below 200% of poverty *	$1,500
Between 200% - 400% of poverty	$3,500
Between 400% - 600% of poverty	$5,500
Above 600% of poverty	20% of income

** The 2003 Federal Poverty Level is $8,980 for an individual and $12,120 for a couple.*

Once the out of pocket limit is reached, beneficiaries are only responsible for 10% of drug expenses.

Specifically, our bill would:

Utilize Marketplace Tools: Our plan would be delivered by entities experienced in managing pharmaceutical benefits. Eligible providers include: Pharmacy Benefit Managers (PBMs), private insurers, employer-sponsored plans, Medicare+Choice plans, states, and even retail pharmacy networks.

Plans would be approved by the Secretary of Health and Human Services, who would also have the flexibility to negotiate and contract with reputable and experienced entities to offer beneficiaries what they want and need. These contracts and plans can evolve and change as technology and needs change.

We're not asking private companies to create a new product or service they don't already provide in the private sector. Many companies, including some insurers,

associations, and pharmacy benefit managers, already offer a drug card that allows participants to receive negotiated discounts on prescription drugs. The more beneficiaries plans enroll, the greater market leverage they have to negotiate for better prices - not just for Medicare beneficiaries - but for all their participants.

Although private entities would be responsible for negotiating discounts, determining which drugs are covered, and administering the plan, they would not bear any risk for the catastrophic benefit.

However, plans still have the incentive to negotiate for better discounts. The better the plan's discounts, the more beneficiaries they enroll. The more beneficiaries they enroll, the greater the plan's negotiating power. The greater the plan's negotiating power, the more money the plan saves. If seniors are dissatisfied with the prescription drugs and discounts available under their drug card plan, they may choose to enroll in a different plan the following year.

The federal government would not be selling, setting, or negotiating prices for prescription drugs. Private entities or states, not the federal government, would determine what prescription drugs are covered. The drug formulary would be determined by each individual drug card plan, in accordance with clinical guidelines and formulary standards established by the Secretary.

Put simply, this legislation would use existing free-market mechanisms such as consumer choice and competition to control costs and secure discounts on prescription drugs for seniors, rather than imposing federal controls that would limit innovation.

Immediate Impact: Our program would take effect six months after enactment - possibly as early as the first half of 2004. Other bills under consideration would not take effect until 2006 or later.

Affordable For Both Seniors and Tax Payers: Beneficiaries would not have to pay monthly premiums or deductibles. Seniors would only pay a $25 annual fee to participate, as well as a small co-payment for prescriptions after they reach their out-of-pocket limit. The $25 fee would be waived for beneficiaries with incomes less than 200% of poverty.

CBO has scored this legislation at $335 billion over ten years, assuming 100% uptake by seniors. This cost is well within the $400 billion set aside in the FY2004 Budget Resolution, and even leaves funds for Medicare reforms.

Permanent: It is an immediate step that can be taken to help seniors. Moreover, the program complements, rather than replaces, the private prescription drug coverage that two-thirds of retirees have now. Finally, our legislation does not sunset, allowing plans to continue to build enrollment and negotiate discounts.

Complement existing coverage: This legislation would preserve, complement, incentivize and improve private employer coverage. Two-thirds of seniors already have some form of prescription drug coverage through private insurers and employers. Most of these plans already offer front-end or first dollar coverage for prescription drugs.

As a result, any legislation offering front-end coverage would likely cause private insurers and employers to restrict their prescription drug benefit or drop it altogether. But by offering discounts and protection from high out-of-pocket drug expenses, this legislation would complement -- rather than replace -- the private front-end drug coverage that two-thirds of seniors already possess.

Conclusion:

Our bill would ensure that every senior could afford to take part and benefit from their participation. But prescription drugs are just one piece of the Medicare puzzle, albeit an important one. There are still a number of significant problems with Medicare that can only be addressed through a comprehensive restructuring of the entire program. Medicare is still in danger of becoming insolvent. Beneficiaries don't have access to eye-glasses, hearing aids, dental care or preventive services. Providers continue to be micro-managed, underpaid, and immersed in a sea of paperwork and arcane regulations that force them to spend more time filling out forms than caring for patients.

Clearly, we have much work to do. But a benefit targeted to those who need it most and that protects seniors from catastrophic drug expenses is a good first step.

Thank you for the opportunity to appear before this committee today.

Statement of
The Honorable Donna M. Christensen
Hearing on
A Medicare Prescription Drug Safety Net: Creating A Targeted Benefit For Low-Income Seniors,"
House Government Reform
Subcommittee on Human Rights and Wellness
2154 Rayburn House Office Building
September 24, 2003

Mr. Chairman,

I appreciate your attempt to create a bill to break the impasse that appears to have developed in the Medicare/Prescription drugs conference committee and to meet the needs of lower income seniors while trying to ensure that the elderly, with good prescription plans do not lose them. I thank you for your efforts, however I have a few concerns about your approach.

First let me congratulate you on concentrating on providing progressive help for the low-income. Clearly, this is the population most in need of assistance. It is the population that is filling about 60 percent as many prescriptions as those with higher incomes and those with Rx insurance.

As I understand your bill, seniors with incomes under 100 percent of poverty would be given a discount card 'loaded' with a credit of $2500, which could be drawn down in the purchase of discounted drugs. Once such an individual has incurred $3000 in total prescription drug expenses, they would have protection against any further costs or catastrophic protection. While this is far more generous than many of the bills that have been introduced in recent years, the $500 gap between the maximum amount in the account and the catastrophic $3000 protection is nevertheless a serious problem for the low-income.

I am also concerned about the provisions, which would utilize the Medicaid program to provide a drug benefit. Medicaid funding in many states is being cut, including some seniors being cut from the Medicaid rolls altogether. Additionally and most importantly for me as a representative of an offshore US Territory, I would insist that any utilization of Medicaid to provide a Medicare drug benefit must provide "state-like treatment" for Medicaid funding for the Territories or our seniors would not be able to access the program in the same manner as their counterparts on the mainland.

One other area that I would be interested in is seeing included in this bill is comprehensive and preventative care for persons at high risk for hospitalization and skilled nursing facilities. This is a provision that is included in both the House and Senate prescription drug bills, though the House has the better provision in that it is not just a demo program.

Without such a provision, which is what we needed for all patients who are at high risk for catastrophic disease, of which African Americans and other people of color are the majority, patients will continue to be sicker and cause the cost of care to increase even higher. Without such a provision health costs will continue its skyrocketing rise.

Lastly, limiting coverage in your bill to just seniors who are at low income, although well intentioned, excludes others who are just as much at need. We promised a full benefit package and that is what we should do.

Thank you once again for the opportunity to make these brief comments I look forward to working with you to make this a bill worthy of support of all seniors.